

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 1 2 1 2 8 0			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
George Herman Obersteuffer						8 - 25 - 80						215 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		CAUCASIAN		MONTH	DAY	YEAR	87			MONTHS	YEARS	MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Washington, D.C.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery County			Executive					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Fernwood House						Executive			Boy Scouts			
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Montgomery		Bethesda		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7900 Radnor Road					
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
William Gaul Oberteuffer						Roberta			Kendall						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No			541-36-6155			Mildred H. Oberteuffer Same as #13							Dinner		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>															
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause if any lost															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cardiovascular Heart Disease</i>												1-2 yrs			
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Depression</i> <i>malnutrition</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
									YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>5-7</i> , 19 <i>80</i> , to <i>8-24</i> , 19 <i>80</i> , that (we) last saw the deceased alive on <i>8-12</i> , 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE <i>William H. Kelley M.D.</i>			DEGREE						22c. DATE SIGNED 8-25-80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William H. Kelley M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <i>8218 Wisconsin Ave Bethesda Md.</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/25/80			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crem.			23d. LOCATION CITY OR TOWN Alexandria, Virginia			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland			ADDRESS			25a. DATE REC'D. BY REGISTRAR AUG 28 1980			25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>						

M

TO A HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by a physician, a registered nurse, a licensed practical nurse, or a certified nursing assistant.

พิพิธภัณฑ์วัฒนธรรมไทย จังหวัดเชียงใหม่

TO FUNERAL DIRECTOR. After this certificate has

should be detached for use as the burial/transit permit. Then please remove carbon papers with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

160

1000 1000 1000

Item #15 Film G547 9/10/80 rc
1 - FORM 5 G 548 10/7/80 GB DE
STATE REGISTRAR

1 - STATE REGISTRAR

STATE
REGISTRAR

RC STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 1 2 8 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			LAST			REG. NO.	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Edmund C. ORDZIE							August 12 1980						8:53P M
3. SEX Male		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR August 15 1919		6. AGE (IN YEARS LAST BIRTHDAY) 60			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.							
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) National Naval Medical Center		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) U. S. Air Force			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE New Hampshire		13b. COUNTY Hillsboro		13c. CITY OR TOWN Pelham		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5 Melody Lane					
14. FATHER'S NAME FIRST William		MIDDLE LAST Ordzie		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE LAST Sienko							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1945-65		17. INFORMANT Mrs. Irene Ordzie See item 13		ADDRESS							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hepatic failure complicated by septic shock</u> 5728 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>July 26</u> , 19 <u>80</u> , to <u>August 12</u> , 19 <u>80</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 12</u> , 19 <u>80</u> , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) <input type="checkbox"/> (not) view the body after death.													
22b. SIGNATURE <u>Raymond S. Smith</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED Aug. 13, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Raymond S. Smith</u>		22e. ADDRESS National Naval Medical Center, Bethesda, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 18, 1980		23c. NAME OF CEMETERY OR CREMATORIUM Bellevue Cemetery		23d. LOCATION CITY OR TOWN Lawrence		COUNTY Essex		STATE Mass.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home, Bethesda, Md.		ADDRESS		25. REC'D BY CLERK AUG 8 1980		26. REGISTRATION NO.							

000 81200

BH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021282			
											REG. NO.				
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			MIGUEL			ORTA			AUGUST 16, 1980			6:45 PM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
MALE		WHITE		MARCH 4, 1905			75			MONTHS	YEARS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTGOMERY COUNTY MD.					
Puerto Rico		USA													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
BETHESDA		THE CLINICAL CENTER		Postal Service			US Government								
13a. STATE FLORIDA		13b. COUNTY Dade		13c. CITY OR TOWN MIAMI			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 131 SOUTHWEST 36th Ave.					
14. FATHER'S NAME FIRST Gustavo		MIDDLE Orta		15. MOTHER'S MAIDEN NAME FIRST Maria DeLapay Gracia Arroyo						LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT						ADDRESS					
No		058-24-6340		Rachel Philipsen (Daughter) Same as #13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>SEPSIS AND Adult Respiratory Failure</i>															
1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <i>HEPATO RENAL failure Syndrome</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>metastatic Carcinoma of Esophagus</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Gangrene of Gallbladder</i>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from MAY 15, 1980 to AUGUST 16, 1980 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on AUGUST 16, 1980 , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.															
22b. SIGNATURE <i>Angelo Russo MD PhD</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF <input type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>ANGELO RUSSO</i>		22e. ADDRESS		NATIONAL INSTITUTES OF HEALTH CLINICAL CENTER, BETHESDA, MD 20205											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-19-1980		23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory			23d. LOCATION CITY OR TOWN Washington, D.C.			COUNTY	STATE				
24. FUNERAL DIRECTOR NAME J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>AUG 5 1980</i>											

318

.914 1988

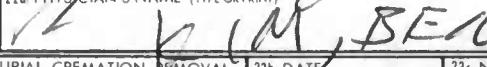
131

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 2 8 3					
REG. NO.																	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Peter			MIDDLE NMN		LAST Palermo		2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
													August 21, 1980				4:45 P M
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH Feb. 11, 1907			6. AGE (IN YEARS LAST BIRTHDAY)		7. IE UNDER 1 YEAR MONTHS 73		8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wisconsin			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.								
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NIH Clinical Center, Bethesda, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer			12b. KIND OF BUSINESS OR INDUSTRY General								
13a. STATE Wisconsin			13b. COUNTY Racine			13c. CITY OR TOWN Union Grove			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1500 Eleventh Ave. 53182					
14. FATHER'S NAME FIRST Joseph			MIDDLE Palermo			15. MOTHER'S MAIDEN NAME FIRST Rose			LAST Locciaso								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) None			16b. SOCIAL SECURITY NO. (IE YES, GIVE WAR OR DATES) 391-01-2777			17. INFORMANT Mrs. Catherine Palermo, Wife			ADDRESS (Same as Above)								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemorrhagic diathesis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. { b) _____ DUE TO, OR AS A CONSEQUENCE OF Carcinoma of the Esophagus { c) _____ DUE TO, OR AS A CONSEQUENCE OF																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN								
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 18, 1980, to August 21, 1980, that <input checked="" type="checkbox"/> (<input checked="" type="checkbox"/> last saw the deceased alive on August 21, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.																	
22b. SIGNATURE 			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 8/22/1980								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 			22e. ADDRESS NATIONAL INSTITUTES OF HEALTH Clinical Center, Bethesda, Md. 20205														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/25/80			23c. NAME OF CEMETERY OR CREMATORIAL West Lawn Mem. Park Racine			23d. LOCATION CITY OR TOWN								
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H.Ave.S.S.Md.						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRATION NO.								

666.0 miles

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item #1 is marked or item #18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 2 8 4								
											REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH			MONTH	DAY	YEAR	2b HOUR		
Eloise M.									PARKER			August 10					1980	2:47A _M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS					
Female			Caucasian			MONTH May 5 DAY 1940 YEAR			40			MONTHS			DAYS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
California			USA						Montgomery											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Bethesda			National Naval Medical Center			Housewife														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Delaware			Kent			Dover			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			R.D. 4, Box 174-K								
14. FATHER'S NAME			FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME								
Barrett						Cook						Marjorie								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			ADDRESS								
No			553563817			Raymond Parker			See item 13											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																				
1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.															CARIORESPIRATORY ARREST					
DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC BREAST CARCINOMA																				
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE								
22a. I certify that (1) (this hospital) attended the deceased from July 30, 1980, to August 10, 1980, that (1) (we) last saw the deceased alive on August 10, 1980, and that in (1) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did (did not) view the body after death															22c. DATE SIGNED					
22b. SIGNATURE <i>S. J. Chubanian</i>															Aug. 11, 1980					
22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS National Naval Medical Center, Bethesda, Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8-12-80			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria			COUNTY Va. STATE								
24. FUNERAL DIRECTOR NAME Metropolitan Funeral Service			ADDRESS Alexandria, Va.			25. RECD. BY REGISTRAR AUG 15 1980			26. REGISTRATION NUMBER <i>111-1111111</i>											
BP																				
DHMH-16 30M 2/80 (VRA 15, 4)																				

008 C 1 AUA

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES.
TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

21285

1. DECEASED NAME (TYPE OR PRINT)			LAST			20. DATE KNOWN OF DEATH MATED			MONTH DAY YEAR		
STEVEN			Michael PARVOLO			8 15 1980			9 33 M		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD	2d. MONTH DAY YEAR	24. HOUR PM			
M	CAUC	12 35 48	31 YRS.	MONTHS	DAYS	8 15 1980	9 33 PM				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
NEW YORK		U.S.A.					MONTGOMERY				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
BETHESDA		SUBURBAN			BARTENDER		RESTAURANT				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS	14. FATHER'S NAME				
MD	MONTGOMERY	POOLESVILLE			17512	COLLIER CIRC	DOMINIC PARVOLO				
15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			WILLIAMS		
ALMA			212-54-1490			MOTHER			6802 NASHVILLE RD LANHAM, MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:			8-14-80			DEPRESSED SKULL FRACTURE					
IMMEDIATE CAUSE (a)			19b. TIME OF INJURY			20. AUTOPSY?					
887- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.			HOUR AM. MONTH DAY YEAR 2:45 P.M. 8 14 1980			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
DUE TO, OR AS A CONSEQUENCE OF			19c. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
(b)			STREET			21d. LOCATION STREET Quince Orchard Rd			CITY OR TOWN Gaithersburg, MD		
DUE TO, OR AS A CONSEQUENCE OF			21e. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21f. DATE REC'D. BY REGISTRAR			COUNTY MD		
(c)			21f. DATE REC'D. BY REGISTRAR			22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			STATE MD		
22b. TITLE (SPECIFY)			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS		
M.D. Dept			BURIAL			8/19/80			PARKLAWN CEMETERY		
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			AUG 18 1980								

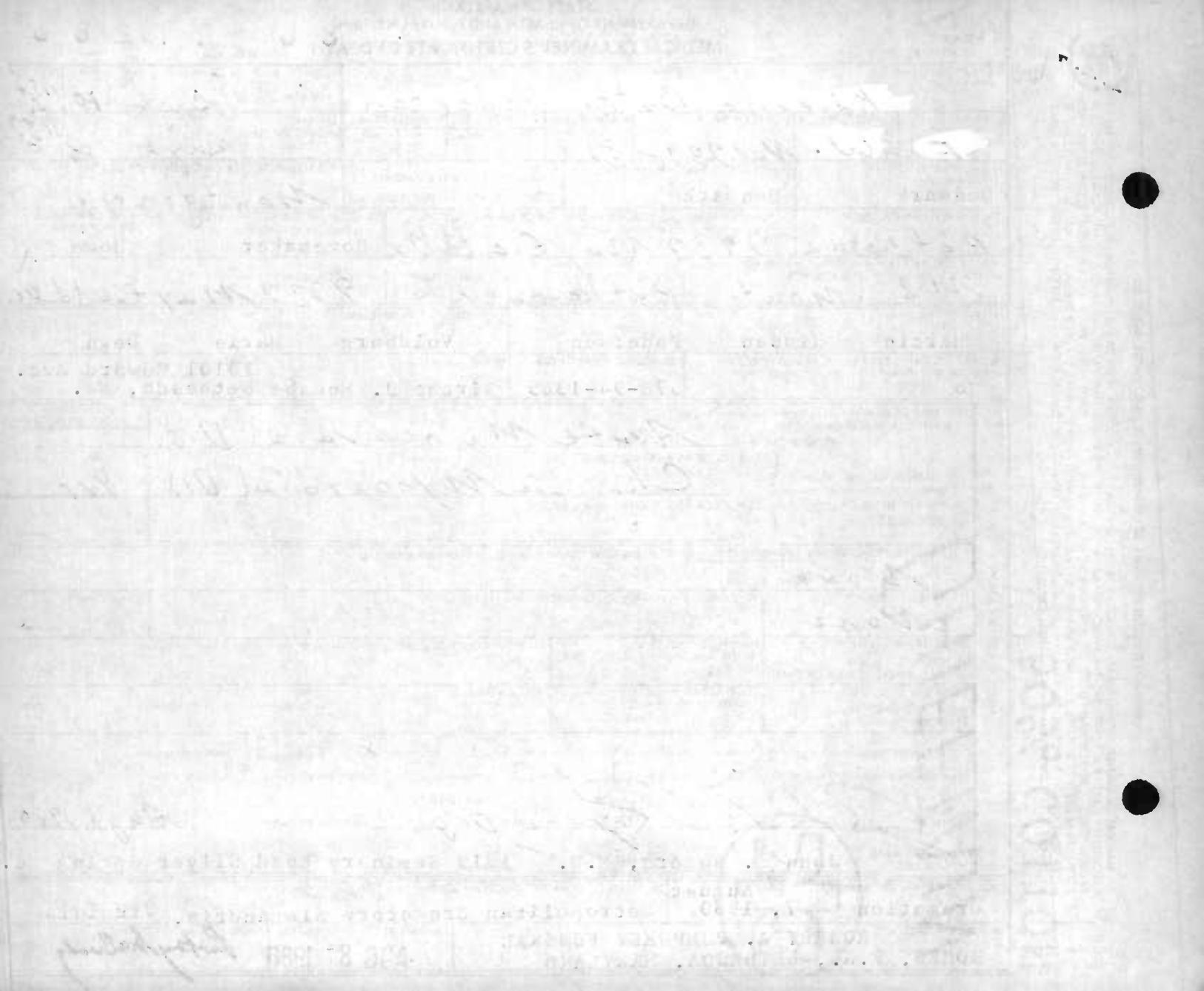
0001-6-F-0001

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILLED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 0 2 1 2 8 6
REG. NO. 1115

1- STATE REGISTRAR			2a. DATE KNOWN OF ESTI- DEATH MATED																	
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			MONTH DAY YEAR								
Betty									Pedersen			Aug 6 1980								
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD						
Female		Caucas.		Nov 28 1881			81 yrs.			MONTHS		DAYS		HOURS		MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Denmark		Denmark								Montgomery MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda			9937 Mayfield Dr.									Homemaker			Home					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			14. FATHER'S NAME						
Md.			Mont.			Bethesda			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		9937 Mayfield Dr.			Martin Nissen Pedersen						
15. MOTHER'S MAIDEN NAME			FIRST			MIDDLE			LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT		
Voldburg												No			578-94-1365			Birthe J. McCabe Bethesda, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Dis.</i>															ADDRESS 10101 Edward Ave.					
<p>4291 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.</p> <p>Due to, or as a consequence of (b) <i>Chronic Myocardial Dis.</i></p> <p>(c)</p>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). <i>None</i>																				
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															TITLE (SPECIFY) John S. Rogers, M.D. Aug 6 1980					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 1919 Seminary Road Silver Spring Md.												DATE SIGNATURE					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE August 7, 1980			23c. NAME OF CEMETERY OR CREMATORIUM Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria, Virginia			25a. DATE REC'D. BY REGISTRAR AUG 8 1980			25b. REGISTRAR'S SIGNATURE <i>Robert A. Pumphrey</i>					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES, P.A., BETHESDA, MARYLAND																				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 72 hours and filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												Cuban Refugee ID: 87 REG. NO. #A23180194		
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
			JOSE PEREZ-PEREZ				August 23, 1980					3:35 P M		
3. SEX			4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
MALE			WHITE		MONTH DAY YEAR March 4, 1940		40			YRS.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Cuba			Cuba							MONTGOMERY COUNTY				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda			The Clinical Center - N.I.H.		Unknown		Unknown			Unknown		Unknown		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			Fort Indiantown Gap	
Pennsylvania			Lebanon		Annville					Cuban/Haitian Task Force			17003	
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST		
(Unknown)							(Unknown)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			None		None		CARDIAC FAILURE			Washington, D.C.				
3949			Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		DUE TO, OR AS A CONSEQUENCE OF (b) Status Post Mitral Valve Replacement and Coronary Artery Bypass Graft		DUE TO, OR AS A CONSEQUENCE OF (c) Rheumatic Heart Disease							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
Coronary Atherosclerosis														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AI WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		21g. CITY OR TOWN			COUNTY		STATE		
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 26, 1980, to August 23, 1980, that <input checked="" type="checkbox"/> (we) lost now the deceased alive on August 23, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.														
22b. SIGNATURE Altagracia M. Chavez MD			DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN		22c. DATE SIGNED							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Altagracia M. Chavez			22e. ADDRESS		National Institutes of Health Clinical Center, Bethesda, MD 20205									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug/27/80		23c. NAME OF CEMETERY OR CREMATORIAL Maryland National Mem.		23d. LOCATION CITY OR TOWN Park, Laurel, P.G.			COUNTY		STATE Maryland		
24. FUNERAL DIRECTOR NAME Chambers Funeral Home			ADDRESS Riverdale, Maryland		25a. DATE REC'D. BY FUNERAL HOME AUG 9 1980		25b. DATE OF DEATH AUG 9 1980							

1000 - 30A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be forwarded for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021288						
												REG. NO.						
1 - STATE REGISTRAR			1. DECEASED NAME			FIRST MIDDLE LAST			2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female			White			MONTH DAY YEAR			81			MONTHS DAYS		HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Maryland			U.S.A.						Montgomery									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			Postal Service						
Takoma Park			WASHINGTON ADVENTIST HOSPITAL			Postmistress												
13a. STATE			13b. COUNTY			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			1600 S. Eads St						
Maryland			Montgomery			Takoma Pk.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			Takoma Tpwers			Arlington, Va 22202			
14. FATHER'S NAME			MIDDLE			15. MOTHER'S MAIDEN NAME			MIDDLE			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Oscar			W.			Ida			P.			3 days						
LAST						FIRST			LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS									
no			228-52-7532A			Mrs. Helen Spurzem												
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY												3 days						
IMMEDIATE CAUSE (a) 4402 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												3 days						
DUE TO, OR AS A CONSEQUENCE OF (b) Ischemic Colon												30 years						
DUE TO, OR AS A CONSEQUENCE OF (c) Anteriorislerotic Peripheral Vascular Disease												30 years						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 1980 to 1980, that (I) (we) last saw the deceased alive on 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Dr. Rosen MD			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 26 Aug, 80									
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Michael Leibowitz, MD			22f. ADDRESS 3608 Carroll Rd Takoma Park, Md 20912															
23a. BURIAL, CREMATION, REMOVAL 1980 Burial			23b. DATE 8-28-80			23c. NAME OF CEMETERY OR CREMATORIAL Dorchester Cem.			23d. LOCATION CITY OR TOWN Cambridge, Dorchester, Md.			STATE						
24. FUNERAL DIRECTOR NAME Curran Funeral Home			ADDRESS 308 High St. Cambridge, Md. 21613			25a. DATE REC'D. BY REGISTRAR AUG 27 1980			25b. REGISTRAR'S SIGNATURE Henry McCready									

(M)

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3 FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8021289					
1- STATE REGISTRAR			2a. DATE KNOWN OR ESTIMATED MONTH DAY YEAR									7b. HOUR 10:00 AM					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2b. DATE MONTH DAY YEAR					
Homer									Pickett			Aug 13 1980					
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			
M		Black		July 21 1980			76 yrs.							Aug 03 1980			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH								
S.C.			U.S.A.						Montgomery MD.								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK) FOR MOST OF WORKING LIFE			12b. KIND OF BUSINESS OR INDUSTRY		
Tels Park			West Advent Hosp									Labor			Mill		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Md			Montgomery		Md Park						7400 Carroll Ave						
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Lewis						Pickett			Winnie			Butler			Pickett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
no			251-14-42874			Mrs Ernestine Griffin			7400-Carroll								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (a) 4291 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.												DUE TO, OR AS A CONSEQUENCE OF					
(b) Chronic myocardial dis.												DUE TO, OR AS A CONSEQUENCE OF					
(c)												Yrs					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?					
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion					
ACTUAL SIGNATURE John S. Rogers M.D. Sep												TITLE (SPECIFY) MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS 1919 Seminary Rd, Silver Spring, Md									DATE SIGNED Aug 13 1980					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 8/18/80			23c. NAME OF CEMETERY OR CREMATORIAL Lincoln Mem. Cemetery Suitland, P.G. Maryland			23d. LOCATION CITY OR TOWN			COUNTY			STATE		
Burial																	
24. FUNERAL DIRECTOR NAME Washington Fun. Chapel			ADDRESS 909-6 St. NW DC									25a. DATE REC'D. BY REGISTRAR AUG 20 1980			25b. REGISTRAR'S SIGNATURE Patsy Melody		
BP																	
DHMH-17 (VR A15 ME (5)) 1SM 7/77																	

NO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 info. 10

rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 10 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 2 9 0											
												REG. NO.											
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Edgar			MIDDLE Niles			LAST Pike			2a. DATE OF DEATH MONTH 08		DAY 29		YEAR 80		2b. HOUR 10:25 PM		
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH 3			DAY 15			YEAR 22			6. AGE (IN YEARS LAST BIRTHDAY) YRS. 58		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.			8			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		MD.						
10. CITY OR TOWN OF DEATH Chevy Chase			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) writer			12b. KIND OF BUSINESS OR INDUSTRY gov't														
13a. STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Chevy Chase			13d. INSIDE CITY LIMITS? YES. <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 3611 Spring St.											
14. FATHER'S NAME FIRST Eugene			MIDDLE			LAST Pike			15. MOTHER'S MAIDEN NAME FIRST Eileen			MIDDLE			LAST Braverman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. WW II			17. INFORMANT Jenny Lee Pike			ADDRESS Same address														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory failure secondary to cancer</u> 185- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first (b) <u>Cancer of the prostate</u> (c) <u>Cachexia</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 7</u> , 19 <u>80</u> , to <u>Aug 28</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8-29-80											
22b. SIGNATURE <u>Gale Minkin M.D., Foy</u>			22c. DEGREE <u>7900 G.A. M.D. 55, M.D. 1992</u>			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. ADDRESS <u>4323 Havard St. S.S., Md. 20906</u>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug 30 80			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crem			23d. LOCATION CITY OR TOWN Alexandria			COUNTY		STATE									
24. FUNERAL DIRECTOR NAME Pearson's Funeral Home, Falls Church			ADDRESS Virginia			25a. DATE OF DEATH RECORD Sep 1 1980			25b. REASON FOR RECORDING														

0-1-810

8 1985 10 20 1985 10 20 1985

1985

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. REFER TO THE INSTRUCTIONS FOR YOUR FILES.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE KEPT WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, OR Removal.

ITEMS #18a-22a Film G548 10/10/80 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												0 2 1 2 9 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH		2b. HOUR			
DIANE J.									PISCIOOTTA			<input type="checkbox"/> 8 19 1980		AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD		MONTH DAY YEAR			
female		black		Aug. 8, 1949		31 yrs.						8 19 1980		6:45 PM			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			MD.					
NEW YORK			UNITED STATES														
10. CITY OR TOWN OF DEATH Takoma Pk.			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BOOKKEEPING CLERK			12b. KIND OF BUSINESS OR INDUSTRY PVT.								
13a. STATE D.C.			13b. COUNTY			13c. CITY OR TOWN WASHINGTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3636 16th Street, N. W.						
14. FATHER'S NAME FIRST ROBERT CARROLL			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST LEOLA		MIDDLE			LAST CANNON			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 072-42-7953			17. INFORMANT ADDRESS ROBERT CARROLL/BROTHER/2343-98th Street,											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 303- IMMEDIATE CAUSE (a) <u>Alcoholism</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?								
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE		<u>Margarita A. Korell</u>										TITLE (SPECIFY) M.D. <u>Assistant</u>		MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)		Margarita A. Korell, M.D.										ADDRESS 111 Penn Street		DATE SIGNED 8-20-80			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE AUG. 26, 1980			23c. NAME OF CEMETERY OR CREMATORIAL WASH. NAT. CEMETERY			23d. LOCATION CITY OR TOWN SUITLAND			COUNTY		STATE			
24. FUNERAL DIRECTOR ROBINSON FUNERAL HOME, INC.									25a. DATE REC'D. BY REGISTRAR SEP 2 1980			25b. LIFE SPAN					
1339 HUNT PLACE, N. E. WASHINGTON, D. C.																	

卷之二

100

2000

267

1990-91 1991-92 1992-93 1993-94 1994-95 1995-96 1996-97 1997-98 1998-99 1999-2000

1953]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21292

1 - STATE REGISTRAR			2a. DATE KNOWN OF DEATH MOTH. DAY YEAR												2b. HOUR						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			Aug 4 1980				12:00 PM					
Rose			Popkin																		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS			8. IF UNDER 24 HRS. HOURS MIN.			9. DATE PRONOUNCED DEAD MONTH DAY YEAR			10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				11. CITIZEN OF WHAT COUNTRY?		12. BALTIMORE CITY OR COUNTY OF DEATH		
F	White	Dec 5 91 88	5							Aug 4 1980			Russia				USA		Montgomery		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
S. C. J. P. -			Rendolph Hills N. Home												Housewife			-----			
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
Maryland			Montgomery			Rockville			NO			263 Congressional Lane			Abraham			Hannah			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY			ADDRESS			19. MEDICAL CERTIFICATION			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No			212-74-7886			Harold Popkin; 4909 McCall St., Rockville			Torninal Bronchial pneumonia									(unknown)			
4292			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF			4292			Arteriosclerotic Cardio Vas. Dis. Yrs.									
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.			(b)			DUE TO, OR AS A CONSEQUENCE OF			4292			Generalized Arteriosclerosis Yrs.									
19. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			Fracture R. hip									
None			-			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A. M. MONTH DAY YEAR P.M. 5 9 19 80			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			Not known			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			21g. CITY OR TOWN			21h. COUNTY			21i. STATE						
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>			TITLE (SPECIFY) M.D. <i>J. Goldstein</i>			MEDICAL EXAMINER			DATE SIGNED <i>Aug 4 1980</i>									
ACTUAL SIGNATURE			EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS															
Burial			23b. DATE 8-5-80			23c. NAME OF CEMETERY OR CREMATORIY Nat'l. Memorial Park			23d. LOCATION CITY OR TOWN Falls Church, Virginia			23e. COUNTY Falls Church, Virginia			23f. STATE Virginia						
24. FUNERAL DIRECTOR NAME Danzansky-Goldberg Chapels			ADDRESS 1170 Rockville Pike			25a. DATE REC'D. BY REGISTRAR AUG 7 1980			25b.												

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Det. 194A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be filled in by the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021293				
												REG. NO.				
1. FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			Samuel Grover POWELL						August 13 1980						2:02A M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			Caucasian			July 31 1920			60			MONTHS	YEARS	MONTHS	YEARS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Pennsylvania			USA						Montgomery							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda			National Naval Medical Center			Chaplain			Air Force							
USUAL RESIDENCE IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION																
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
D.C.			-			Bolling AFB			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			98A Duncan Ave.				
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
William D. Powell			Mary Emma Grover			Yes 1954-80			187 05 7695			Isabelle N. Powell			See item 13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
410- DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF (c)																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that (I) (this hospital) attended the deceased from Aug. 8 1980, to Aug. 13 1980, that (I) (we) last saw the deceased alive on Aug. 13 1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <u>J. E. Schwartz</u>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF <input checked="" type="checkbox"/> PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED							
22e. ADDRESS National Naval Medical Center, Bethesda, Md.												Aug. 14, 1980				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug/18/80			23c. NAME OF CEMETERY OR CREMATORIAL Beaufort National Cem.			23d. LOCATION CITY OR TOWN Beaufort, Beaufort Co., S.C.			COUNTY		STATE		
24. FUNERAL DIRECTOR W. W. Chambers Co.			Silver Spring, Maryland			25a. DATE REC'D. BY REGISTRAR SEP 10 1980			25b. REGISTRAR'S SIGNATURE <u>notary McAleney</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death. With the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

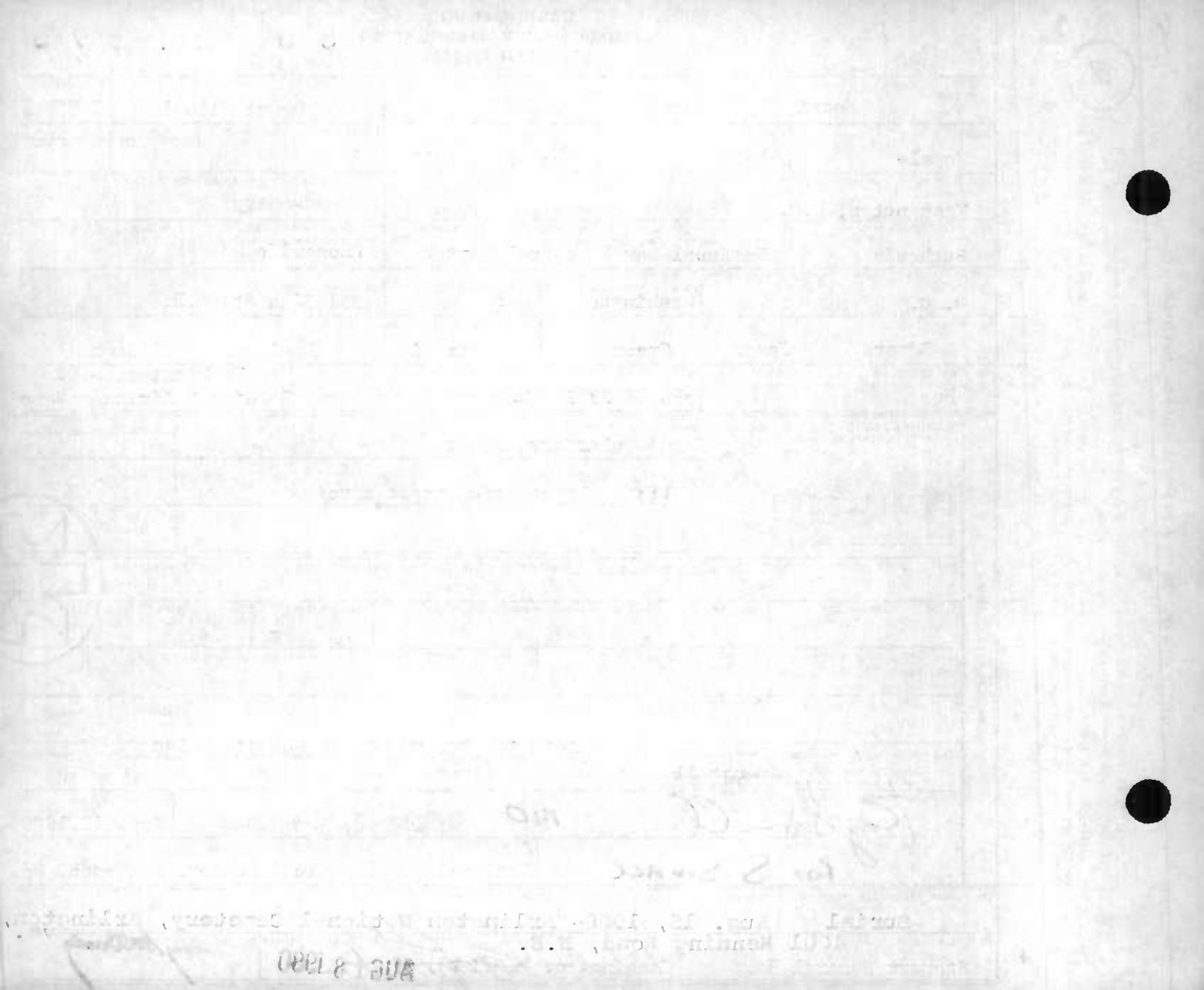
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8021294	
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 8-10-80									2b. HOUR 12 ¹⁵ AM	
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
Hazel M Preller						8-10-80			12 ¹⁵ AM				
3 SEX F		4 RACE W		5 DATE OF BIRTH MONTH 8 DAY 03 YEAR 17			6 AGE IN YEARS LAST BIRTHDAY 63. yrs			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.						
10 CITY OR TOWN OF DEATH Silver Spring		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ins. Agency			12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 11901 New Hampshire			
14 FATHER'S NAME FIRST William		MIDDLE Martin		15 MOTHER'S MAIDEN NAME LAST Bessie Powell									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 237-03-5489		17 INFORMANT Francis Preller (Husband)			ADDRESS Same as above						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 months	
19a. DATE OF OPERATION 1949 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.												19b. DUE TO, OR AS A CONSEQUENCE OF (b) <u>metastatic breast cancer</u> . 18 months	
19c. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Breast cancer - BILATERAL</u> . 1964-1977													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: <u>Bowel Perforation</u>													
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10 Aug 1979</u> to <u>10 Aug 1980</u> , that (I) (we) last saw the deceased alive on <u>10 Aug 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Eugene P. Libe MD</u>			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED <u>Aug 80</u>				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene P. Libe MD.			22f. ADDRESS 10400 Conn. Ave. Kensington, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/13/80			23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven			23d. LOCATION CITY OR TOWN S.S. Mont.			COUNTY STATE Mont. Md.	
24 FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H.Ave. S.S. Md.			25a. DATE REC'D. BY REGISTRAR AUG 14 1980			25b. REGISTRAR'S SIGNATURE <u>Jeffrey McCreary</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 2 9 5	
REG. NO.													
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Naomi			Lucille	PRESTON		August			11	1980		7:05P M	
3. SEX			4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			Negro	MONTH DAY YEAR			48			MONTHS	YEARS	MONTHS	HOURS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.			USA						Montgomery				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda			National Naval Medical Center			Housewife							
13a. STATE D. C.			13c. CITY OR TOWN Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 331 36th St. N.E.			MD.	
14. FATHER'S NAME FIRST Edward			MIDDLE James	LAST Green	15. MOTHER'S MAIDEN NAME FIRST Naomi			MIDDLE Louise	LAST Williams				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
No			578 46 2332			Raymond L. Preston, Soldier & Airmen's Home			Washington, D.C.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
1749 Cardiopulmonary arrest													
DUE TO, OR AS A CONSEQUENCE OF (b) <input checked="" type="checkbox"/> Metastatic breast carcinoma													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from July 29, 1980, to August 11, 1980, that <input type="checkbox"/> (we) last saw the deceased alive on August 11, 1980, and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.												22c. DATE SIGNED Aug. 12, 1980	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roy S Small			22e. ADDRESS National Naval Medical Center, Bethesda, Md.			DEGREE MD	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 15, 1980- Arlington			23c. NAME OF CEMETERY OR CREMATORIAL Arlington National Cemetery, Arlington, Va.			23d. LOCATION CITY OR TOWN				
24. FUNERAL DIRECTOR NAME Stewart Funeral Home			ADDRESS Washington, D.C.			23e. DIRECTED BY REGISTRAR Aug. 18, 1980			23f. REGISTRAR'S SIGNATURE Aug. 18, 1980				



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 21296	
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OR ESTIMATED DEATH			2b. HOUR	
			James M. Prettyman						Aug 25 1980			6:35 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR. IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
M		W		Sept 22 '36		43 yrs.		MONTHS DAYS HOURS MIN.		Aug 25 1980		7:00 P.M.	
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.						Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
St. Louis, Mo.		Holy Cross Hosp										Mech. Engineer	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		12b. KIND OF BUSINESS OR INDUSTRY			
Mo.		Caroline		Preston		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D. 1 Box 76A		Mech. Mech.			
14. FATHER'S NAME		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT			
William		Wesley		Prettyman, Jr.		Esther		215-38-6459		Donna P. McDougal see item #13			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		19. PART I DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		215-38-6459				Acute myocardial Dis		IMMEDIATE CAUSE (a)					
4291		Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF		(b)		Chronic myocardial Dis.		Yrs.			
				DUE TO, OR AS A CONSEQUENCE OF		(c)							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
None		None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY?	
None												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)		19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that I took charge of the remains described above, held on death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>											
ACTUAL SIGNATURE		TITLE (SPECIFY)		John S. Rogers, M.D.		ADDRESS		MEDICAL EXAMINER		D.S. SIGNED Aug 25 1980			
EXAMINER'S NAME (TYPE OR PRINT)													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
Burial		8-28-80		Spring Hill Cem.		Easton		Talbot		Md.			
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Newnam Funeral Home		Easton, Md.		AUG 27 1980		Ricky McElroy							

2402 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

3 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be forwarded for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 21297				
												REG. NO.				
1. FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR									2b. HOUR				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			8-1-80 3:35 AM				
HELEN G. PRICE																
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN				
FEMALE		White		10 28 1902			77 YRS									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
Virginia		U. S. A.					MONTGOMERY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
SKULL SPLINT		HOLY CROSS		Housewife												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS						
Md.		Montgomery		Sil. Spr.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			733 Sligo Avenue						
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE		LAST				
Clifford		Elijah		Greene			Sadie					Greene				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
NO		577-10-00168		Ralph F. Price			733 Sligo Ave.			Armed.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>																
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>												20 years				
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Mental disorder, heart disease</u>												60 yrs.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE				
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from <u>July 31</u> , 19 <u>68</u> , to <u>July 31</u> , 19 <u>80</u> , that <input type="checkbox"/> (we) last saw the deceased alive on <u>July 31</u> , 19 <u>80</u> , and that in <input type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) (did) (did not) view the body after death.																
22b. SIGNATURE				DEGREE												
James Coleman																
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		JAMES COLEMAN		22d. ADDRESS			22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22f. DATE SIGNED 8/1/80						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE				
Burial		8/4/80		Cedar Hill Cemetery			Suitland, Maryland									
24. FUNERAL DIRECTOR NAME		ADDRESS		8434 Ga. Ave.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
Warner E. Pumphrey, Inc.				Sil. Spr., Md.			AUG 8 1980			John E. Pumphrey						

W

•

0001 0000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be

referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death.

with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 2 9 8			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Adella Elizabeth Pulford						August 4, 1980						8:48pm	
3. SEX Female		4. RACE White		5. DATE OF BIRTH April 15, 1924		6. AGE (IN YEARS LAST BIRTHDAY) 56			IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Jessup, Pa.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County			MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, NIH, Beth. Md		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Home						
13a. STATE Michigan		13b. COUNTY		13c. CITY OR TOWN Farmington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 23210 Cass Ave. 48024					
14. FATHER'S NAME Fracadino		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME Clara		16. ADDRESS			Pennoni				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 363-26-8549		17. INFORMANT Mr. David W. Pulford Sr. (husband)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cachexia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1549 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pancreatic Carcinoma													
1549 Due to, or as a consequence of (b) Pancreatic Carcinoma													
1549 Due to, or as a consequence of (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from December 26 1979, to August 4, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 4, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (not) view the body after death.										22b. DATE SIGNED 6 Aug 80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel E. Tepper		22e. DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8-6-80		23c. NAME OF CEMETERY OR CREMATORIAL Lee's Crematory		23d. LOCATION CITY OR TOWN Washington, D.C. 20002		COUNTY		STATE			
24. FUNERAL DIRECTOR Lee Funeral Home 300-4th St. N.E., Wash. D.C. 20002		25. R.R. C. B. C. B. C. R. R. 25 AUG 11 1980											
BP													
DHMH 1630M 2/80 (VRA 15, 4)													

ONE LIAVA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 2 9 9							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR							
Margaret			E.	Rabbit		August 18, 1980						11:18A M							
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS							
Female		white		May 4 1913			67			MONTHS	YEARS	HOURS	MIN.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Washington, DC		USA								Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)							
Olney		Montgomery General Hospital										Director							
13a. STATE Maryland												13b. COUNTY Montgomery		13c. CITY OR TOWN Rockville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4017 Heathfield Road,	
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST	12b. KIND OF BUSINESS OR INDUSTRY Nurses Residence								
Arthur				Asheton	Agnes					Berrymen									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. CAUSE OF DEATH PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
-----		578-09-4066		Elizabeth A. Vicino-Owings, Maryland			Respiratory Arrest		3 minutes										
496- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												b. Chronic Obstructive Airways Disease 15 yr.							
d. DUE TO, OR AS A CONSEQUENCE OF e. DUE TO, OR AS A CONSEQUENCE OF																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION 3-18-80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED cecal volvulus			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from May 9, 1980, to August 18, 1980, that (I) (we) last saw the deceased alive on August 18, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8-18-80							
22b. SIGNATURE Frank J. Mayo, M.D.		DEGREE		22d. PHYSICIAN'S NAME Frank J. Mayo, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. ADDRESS 16220 Frederick Rd. Gaithersburg, Md. 20760										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-21-1980		23c. NAME OF CEMETERY OR CREMATORIAL Parklawn Cemetery			23d. LOCATION CITY OR TOWN Rockville		COUNTY Montgomery		STATE Md								
24. FUNERAL DIRECTOR NAME Walter E. Pumphrey, Inc. 8434 Ga. Ave., S.S. Md.		ADDRESS 8434 Ga. Ave., S.S. Md.		25a. DATE REC'D. BY REGISTRAR AUG 20 1980			25b. REGISTRAR'S SIGNATURE Keith D. Clark												

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

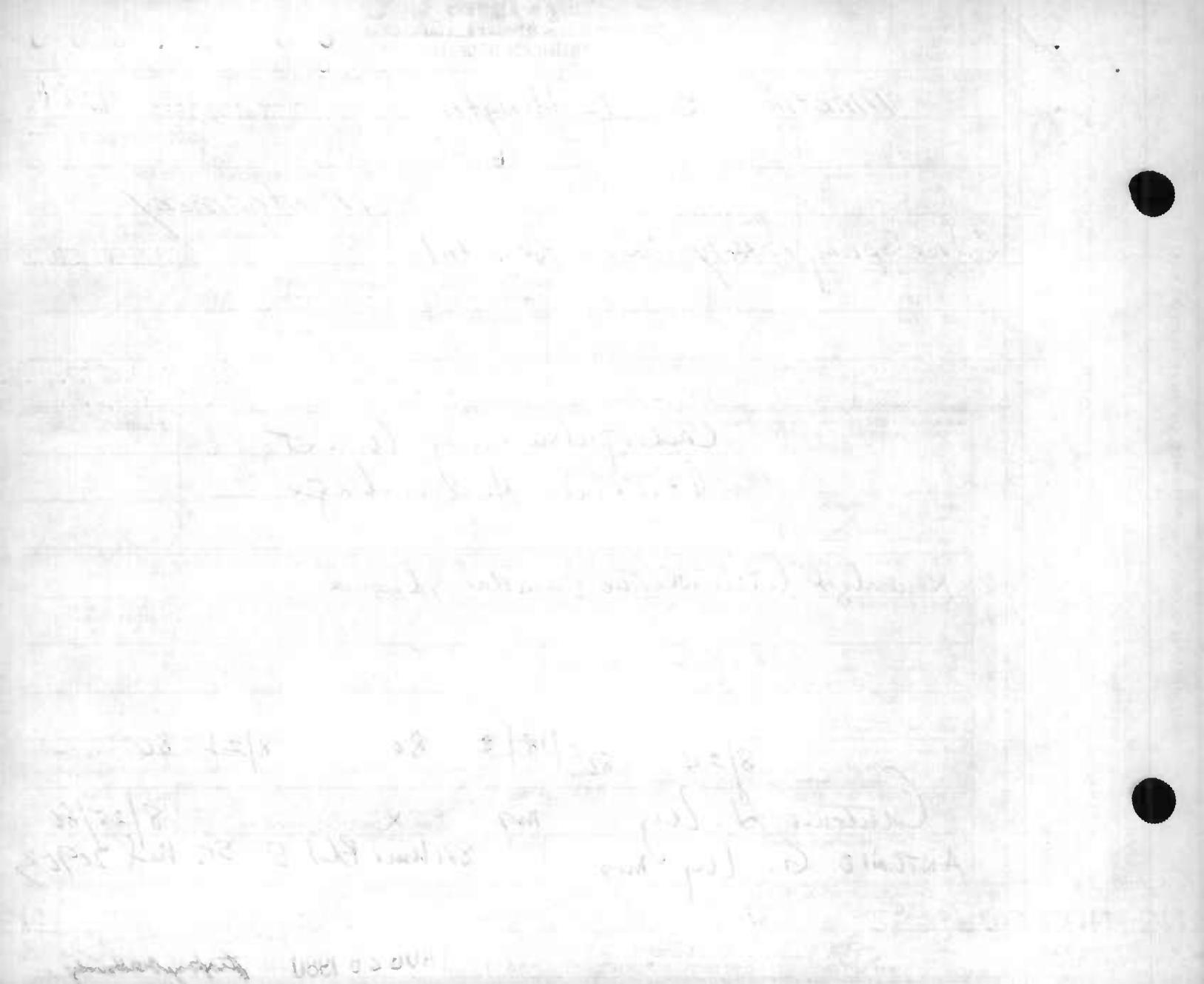
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021300		
										REG. NO.		
1. DECEASED NAME TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
MALE			Burke Reddington			AUGUST 25, 1980			1238 A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
MALE		WHITE		MARCH 16, 1914			66 YRS			IF UNDER 24 HRS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN		
WASHINGTON D.C.		U.S.A.					Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		
Silver Spring		Holy Cross Hospital								12b. KIND OF BUSINESS OR INDUSTRY		
13. STATE		13a. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
MARYLAND		PRINCE GEO.		ADELPHI					9010 RIGGS ROAD			
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
PATRICK REDDINGTON			DELIA BURKE									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO.			17. INFORMANT SISTER DELIA T. REDDINGTON			ADDRESS 2600 TUNLAW RD., N.W. WASHINGTON, D.C.			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Generalized Autonomic Vasomotor Disease			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
431- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)			DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/18/80, to 8/25/80, that (I) (we) last saw the deceased alive on 8/24/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Antonio G. Uy mg			DEGREE mg ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/25/80						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANTONIO G. UY mg			22e. ADDRESS 831 Linda Blvd E 55, Ned 20903									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/28/80			23c. NAME OF CEMETERY OR CREMATORIAL GATE OF HEAVEN			23d. LOCATION CITY OR TOWN SILVER SPRING MONT MD.			
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS ADDRESS 500 LINTV. BLVD. W. SILVER SPRING, MD. 20901						25a. DATE REC'D. BY REGISTRAR AUG 26 1980			25b. REGISTRAR'S SIGNATURE F. J. Collins			

BP

DHMH-16 25M
(VRA 15, 4) 1/79

5903



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE FORMS 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 3 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

15

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21301

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN <input type="checkbox"/> MONTH DAY YEAR OF ESTI- DEATH MATED				2b. HOUR MONTH DAY YEAR
WILLIAM	ALYSIUS	REUTEMANN JR.	8/25/80	PM						
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	8/27/80	PM		
Male	CAUC	8 14 19	61 yrs.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.		USA				MONTGOMERY				
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
CHEVY CHASE		4601 N. PARK Ave				lawyer		U.S. Gov't		
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE MD		13b. COUNTY Montgomery	13c. CITY OR TOWN Chevy Chase	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4601 N. PARK Ave		
14. FATHER'S NAME FIRST		MIDDLE	LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST		
William		A.	Reutemann, Sr.		Kathryn			Fleming		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		4800 ADDRESS Kathryn R. Wilcox		Rockville, Md.		
Yes		WW II		461-44-3982						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>GASTRO INTESTINAL HEMORRHAGE</u> ACUTE Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. DOUE TO, OR AS A CONSEQUENCE OF (b) <u>ETHANOLISMS</u> DOUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR AM. MONTH DAY YEAR P.M. 8/25/80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		COLLAPSED IN FRONT OF REFRIGERATOR				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET 4601 N. Park Ave CITY OR TOWN Chevy Chase COUNTY Montgomery STATE Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										TIME (SPECIFY) 12/27/80
EXAMINER'S NAME (TYPE OR PRINT) James C. Mayle										MEDICAL EXAMINER ADDRESS: 820 Wisconsin Ave Bethesda MD
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 30, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Gate of Heaven Cen.		23d. LOCATION CITY OR TOWN Silver Spring, Md.		DATE SIGNED 12/27/80		
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A.		ADDRESS Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR SEP 3 1980		25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey				



TO HOSPITAL ATTENDING PHYSICIAN:

executed within 24 hours after death. Page 4 may be

should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of burial with the STATE Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event

MEDICAL CERTIFICATION

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 1 3 0 2
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Icilda m Riley			2a. DATE OF DEATH MONTH DAY YEAR 1 8 3 80	2b. HOUR 115 A.M.
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 2 26	6. AGE (IN YEARS LAST BIRTHDAY) 54	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kingston, Jamaica	7b. CITIZEN OF WHAT COUNTRY? U. S.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery	10. CITY OR TOWN OF DEATH Silver Spring
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Animal Care Taker	12b. KIND OF BUSINESS OR INDUSTRY Naval Med.
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Sil. Spr.
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1604 Wilson Place	
14. FATHER'S NAME FIRST MIDDLE LAST Hubert Charles			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Peck	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 577-68-1712	17. INFORMANT Silvano R. Riley, Husband	ADDRESS SAA
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiomyopathy 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Hypertension (c) Renal Failure				
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 yrs 20 yrs 1 mo				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Acidosis Seizures, Pericarditis Pericardial Tamponade				
19a. DATE OF OPERATION 7/9/80		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pericardial Tamponade	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> TO DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) At work		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) X	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) X	21f. LOCATION STREET X	CITY OR TOWN X COUNTY STATE
22a. I certify that (I) (this hospital) attended the deceased from 7/6/80 to 8/3/80 , 19 80 , to 8/3/80 , 19 80 , that (I) (we) last saw the deceased alive on 8/2/80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and I am the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Raymond A. Bass			DEGREE X	22c. DATE SIGNED 8/5/80
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RAYMOND A. BASS		22e. ADDRESS 16220 FREDERICK AVE GAITHERS RUN 20760		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/8/80	23c. NAME OF CEMETERY OR CREMATORIAL Md. Nat'l Mem. Park	23d. LOCATION CITY OR TOWN Laurel P.G. COUNTY STATE Maryland
24. FUNERAL DIRECTOR NAME John M. Bass		ADDRESS 7400 Ga. Ave., N.W.	25a. DATE REC'D. BY REGISTRAR AUG 14 1980	25b. REGISTRAR'S SIGNATURE Lydia Bradley

Digitized by srujanika@gmail.com

Indirect bandgap visible under UV light

www.Fordable.com

• 201 • 512 - [View original](#) [Reply](#)

200

10

2000-01

1000

882 barrett.williams@monroecc.edu

TO HOSPITAL OR ATTENDING PHYSICIAN

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death, retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

111

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 0 2 1 3 0 3

REG NO

I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
EVELYN L. RIPPSS			JUNE 11, 1919			8 17 80			8 35 P.M.		
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery MD.				
10. CITY OR TOWN OF DEATH Bethesda		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ECONOMIST			12b. KIND OF BUSINESS OR INDUSTRY US GOV'T.				
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN GAIthersburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 9724 QUILL PLACE		
14. FATHER'S NAME MAX		MIDDLE RIPPS		15. MOTHER'S MAIDEN NAME DORA			16. ADDRESS BETHESDA, MARYLAND		ZEITCHICK		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 068-14-9874		17. INFORMANT JASON HORN, 6109 LONE OAK DRIVE			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days				
<p>18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY</p> <p>IMMEDIATE CAUSE (a) <u>Pneumonia</u></p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <u>Brain Degeneration of unknown</u></p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>DUE TO, OR AS A CONSEQUENCE OF (c) <u>etiology</u></p> <p>months</p>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
<p>22a. I certify that (I) (this hospital) attended the deceased from <u>7/15</u>, 19 <u>80</u>, to <u>8/17</u>, 19 <u>80</u>, that (I) (we) lost sow the deceased alive on <u>8/17</u>, 19 <u>80</u>, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.</p> <p>22b. SIGNATURE <u>Stephen Newman</u> DEGREE <u>MD</u></p> <p>ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/></p> <p>22c. DATE SIGNED <u>8/17/80</u></p>											
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS 5411 WEST CEDAR LANE, BETHESDA, MARYLAND									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/20/1980		23c. NAME OF CEMETERY OR CREMATORIAL KING DAVID MEMORIAL GARDEN			23d. LOCATION CITY OR TOWN FALLS CHURCH		COUNTY STATE VIRGINIA		
24. FUNERAL DIRECTOR DONALD M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N. W., WASHINGTON, D. C.		25a. DATE REC'D. BY REC'D. BY AUG 21 1980			25b. REGISTRAR'S SIGNATURE <u>Stephen Newman</u>						

DHMH-16 25M
(VRA 15, 4) 1/79

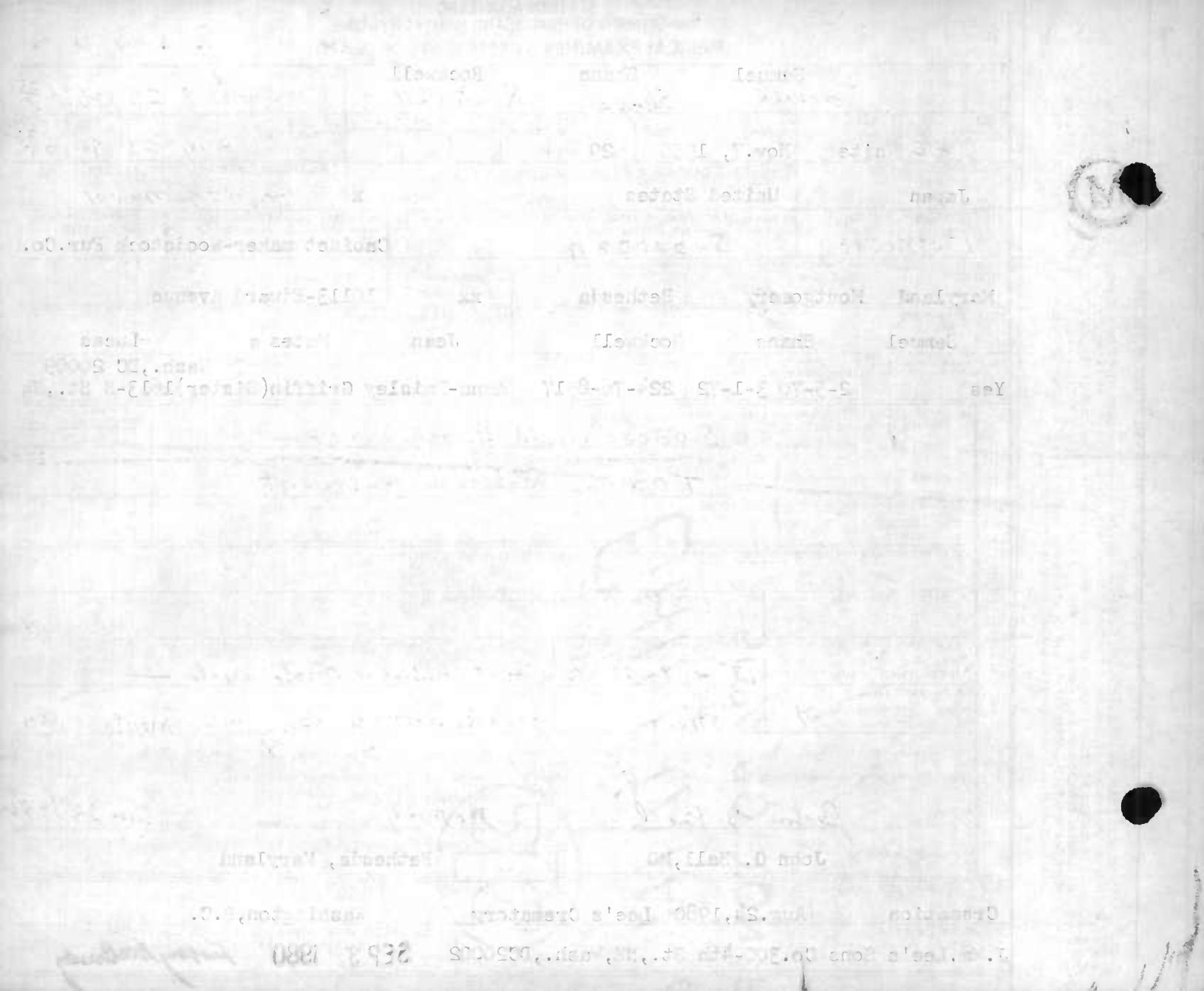
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 21304

1. DECEASED NAME (TYPE OR PRINT)			FIRST Samuel	MIDDLE Shane	LAST Rockwell	2a. DATE KNOWN OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
			<i>Samuel</i>			<i>Shane Rockwell</i>			<i>8 23 1980 5:22 PM</i>		
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR	
MALE	White	Nov. 7, 1950	29 yrs.			<i>Aug 23 1980</i>			<i>5:22 PM</i>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			
Japan		United States						<i>Montgomery</i>			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban			Cabinet maker-Woodstock Fur. Co.						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
Maryland		Montgomery		Bethesda		YES <input checked="" type="checkbox"/>		10113-Edward Avenue			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST	
Samuel		Shane		Rockwell		Jean		Mapes		Lucas	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		16c. INFORMANT		ADDRESS					
Yes		2-5-70 3-1-72		224-76-8517		Anna-Paisley Griffin(Sister)		Wash., DC 20009			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Subarachnoid Hemorrhage -</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <i>Trauma - Motorcycle Accident</i> DUE TO, OR AS A CONSEQUENCE OF (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20d. AUTOPSY?	
										YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>lost control of motorcycle</i>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
		<i>Street</i>		<i>3509 Randolph Rd. Kensington</i>		<i>Mont.</i>		<i>Mont.</i>		<i>Md.</i>	
22a. I certify that I took charge of the remains described above, held an		Autopsy <input type="checkbox"/>		Inspection <input checked="" type="checkbox"/>		Inquiry <input checked="" type="checkbox"/>		and in my opinion			
death resulted from: Natural causes <input type="checkbox"/>		Accident <input checked="" type="checkbox"/>		Suicide <input type="checkbox"/>		Homicide <input type="checkbox"/>		Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE		<i>John G. Ball</i>		TITLE (SPECIFY) M.D.		<i>Deputy</i>		MEDICAL EXAMINER			
EXAMINER'S NAME (TYPE OR PRINT)		John G. Ball, MD		ADDRESS		Bethesda, Maryland					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE	
Cremation		Aug. 24, 1980		Lee's Crematory		Washington, D.C.					
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
J.Wm. Lee's Sons Co. 300-4th St., NE, Wash., DC 20002				SEP 3 1980		<i>John G. Ball</i>					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM FM 3. RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

44
BP
DHMH-17
(VR A15 ME(5))
15M7/77



210 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

2 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORT ANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 3 0 5 REG. NO.			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
			Esther Elnora Roderick						August 7, 1980			9:00 P.M.			
3 SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			7 IF UNDER 1 YEAR			
Female			Caucasian			MONTH DAY YEAR			87			# UNDER 24 HRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MONTHS DAYS HOURS MIN			
No. Dakota			U.S.A.						Montgomery			MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY						
Silver Spring Fairland			Fairland Nursing Home			Housewife			Run home						
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b COUNTY			13d INSIDE CITY LIMITS?			13e STREET ADDRESS						
Md.			Montgomery			YES <input type="checkbox"/> NO <input type="checkbox"/>			215 Lexington Drive						
14. FATHER'S NAME			LAST			15. MOTHER'S MÄDEN NAME									
FIRST MIDDLE			KELLER			FIRST MIDDLE			U. ZACHER						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b SOCIAL SECURITY NO.			17 INFORMANT			ADDRESS						
No			267-42-6707			SON DONALD R. RODERICK			RT 1, BOX 202 ROCK HALL, MARYLAND						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebral arteriosclerosis, severe</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4370 3 yrs															
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____															
DUE TO, OR AS A CONSEQUENCE OF (c) _____															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Coronary heart disease, Neoplasm of colon, probable</i>															
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a I certify that (i) this hospital attended the deceased from 8/24, 1977, to 8/7, 1980, that (ii) we last saw the deceased alive on 7/30, 1980, and that in (my) our opinion death occurred on the date and hour and from the causes stated above (i) we did not view the body after death.															
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED						
George S. Kenton, MD												Aug. 8, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
George S. Kenton			10,620 Georgia Avenue Silver Spring, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY STATE			
Burial			8/11/80			Arlington Nat'l Cem.			Arlington			Virginia			
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE						
FRANCIS J. COLLINS			500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			AUG 14 1980			F. J. Collins						

0891 7 2009	100000	20000	10000
2001 12 30	200000	100000	50000
2002 01 01	200000	100000	50000
2002 01 01	200000	100000	50000
2002 01 01	200000	100000	50000

2001 12 31

0891 8 2009
2002 01 01

2002 01 01

G.Y.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be referred by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021306			
REG. NO.															
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
			Elizabeth Rosser Ross						August 8, 1980			6:35p.m.			
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female			White			September 11, 1937			42			MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.						
Washington, D.C.			USA												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			NIH Clinical Center, Bethesda, Md Ret:			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda			Clinical Center, Bethesda, Md Ret:									Fed. Government			
13a. STATE Virginia			13c. CITY OR TOWN Annandale			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 7918 Schuyler Court						
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST												
Rosser L. Fulford			Mary M. Banks												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT									
No.			217-34-8823			Mr. David C. Ross, Husband (same as above)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1830 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															
1830 DUE TO, OR AS A CONSEQUENCE OF PNEUMONIA (b)															
DUE TO, OR AS A CONSEQUENCE OF OVARIAN CANCER (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 15, 1980, to August 8, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 8, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (XXX) view the body after death.															
22b. SIGNATURE Douglas Blayney MD												22c. DATE SIGNED 10 Aug 80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas Blayney			23c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/10/1980			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN Alexandria, Virginia						
24. FUNERAL DIRECTOR NAME Everly Funeral Home Fairfax, Va			ADDRESS			25a. RECEIVED BY AUG 13 1980			25b. DEATH SIGNATURE						

1988.02.06.6

130 MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, AND 3 TO THE FUNERAL DIRECTOR: PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8021307				
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			20. DATE KNOWN OF EST. DEATH MATED			MONTH DAY YEAR	
John Milton Rowe												<input type="checkbox"/> Aug 13 1980			12:00 PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE Pronounced DEAD			MONTH DAY YEAR	
M		W		May 19 1922 1980		YRS.						Aug 13 1980			12:00 PM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH				
WASHINGTON, D.C.			U.S.A.									Montgomery MD				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Olney			Mont. General Hosp									REAL ESTATE SALESMAN				
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Md.			Mont.			Rockville						5208 University Dr.				
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S M AIDEN NAME FIRST			MIDDLE			CONSIDINE	
MILTON			F.			ROWE			SOPHIE							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
YES			WW II			577-32-2496			ELIZABETH M. ROWE			SAME AS 13			WIFE	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial Dis.</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4291 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																
(b) _____ DUE TO, OR AS A CONSEQUENCE OF																
(c) _____ DUE TO, OR AS A CONSEQUENCE OF																
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>None</i>																
19a. DATE OF OPERATION <i>None</i>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY?				
												<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 79			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															TITLE (SPECIFY)	
<i>J. S. Rogers, M.D.</i>															MEDICAL EXAMINER	
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS															ADDRESS 1919 SEMINARY ROAD, SILVER SPRING, MD.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 8/16/80			23c. NAME OF CEMETERY OR CREMATORIAL FT. LINCOLN			23d. LOCATION CITY OR TOWN BRENTWOOD			COUNTY PRI GEO			STATE MD.	
BURIAL																
24. FUNERAL DIRECTOR NAME			FRANCIS J. COLLINS						25a. DATE REC'D. BY REGISTRAR AUG 14 1980			25b. REGISTRAR'S SIGNATURE <i>Patricia Holmes</i>				

गुरुद्वारा

०८१२१३०८

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, part should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021308		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR			
Caroline NMN Sadler						8 22 80			4:55 P.M.			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH April DAY 12 YEAR 1941			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
female		white					39					
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Washington, D.C.		USA					Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park		Washington Adventist Hosp.			Receptionist			Animal Hosp.				
13a. STATE Maryland										13b. COUNTY Montgomery		
13c. CITY OR TOWN Takoma Park										13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 6825 Red Top Road #5												
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Alfred E. Savage			Ellen Montiort Coward									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 213 40 9617			17. INFORMANT Ellen Savage			ADDRESS 7000 Sulky Lane Rockville, MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year		
5712 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										Alcoholic Cirrhosis (Laennec's of the liver Cirrhosis)		
DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>August 20, 1980</u> to <u>August 22, 1980</u> , that (I) (we) lost saw the deceased give birth on <u>August 22, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Maurice Rosemarie MD										DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		
22c. DATE SIGNED 8/23/80												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN S. ROSEMARIE MD			22e. ADDRESS 10500 SUMMIT AVE. KENSINGTON, MD. 20795									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE 8/26/80			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crematory			23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia			
24. FUNERAL DIRECTOR NAME Tyson Wheeler Funeral Home, Inc. 1331 Rockville Pike Rockville, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 26 1980			25b. REGISTRAR'S SIGNATURE			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 0 2 1 3 0 9	
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. HOUR	
Oliver						Sanders Jr			<input checked="" type="checkbox"/> 8 7 19 80			M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD	MONTH DAY YEAR	2d. HOUR 11:26 A M	
Male	Black	16 Aug 1927	52 yrs.							8	7 19 80		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
South Carolina		Spartanburg, USA						Montgomery County, MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Takoma Park		Washington Adventist Hospital			Construction			Private					
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE D.C.	13b. COUNTY None	13c. CITY OR TOWN Washington	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 8030 Eastern Ave, N.W.							
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Oliver Sanders Sr		Lillie M. Sanders											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Yes U.S. Army		Unknown			Delores Black (Sister)			8030 Eastern Ave, N.W.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiomyopathy												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4254 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) (c) } DUE TO, OR AS A CONSEQUENCE OF } DUE TO, OR AS A CONSEQUENCE OF } (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). Cirrhosis of Liver													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		Virginia L. Dolan			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.			ADDRESS			111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 12 Aug 80		23c. NAME OF CEMETERY OR CREMATORIAL Harmony Cemetery			23d. LOCATION CITY OR TOWN Landover, P.G.C., Maryland			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME		Modern Funeral Home 3821-14th St, N.W. Washm D.C.			25a. DATE REC'D. BY REGISTRAR AUG 13 1980			25b. REGISTRAR'S SIGNATURE Fay H. Dolan					
BP													
DMH-17 (VR A15 ME (5)) 15M 7/77													

über 8 JAHRE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021310						
										REG. NO.						
1 - STATE REGISTRAR			2a. DATE OF DEATH							MONTH	DAY	YEAR	2b. HOUR			
(TYPE OR PRINT)			William I SAUNDERS							8. 8.	80	8. 80	8 * A M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male		White		MONTH	DAY	YEAR	11	25	15	64	YRS.	MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
New York		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Ashton		801 Ashton Road							Sales Manager			Appl. Store				
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13b. STREET ADDRESS						
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY, OR TOWN Ashton			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 801 Ashton Road						
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME												
Carle O. Warren				Ella C. Halle												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS Same as above						
Yes		WWII		083 01 5938			Betty W. Saunders (Wife)									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH						
1629 Brain metastasis										1 mo						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) DUE TO, OR AS A CONSEQUENCE OF Branche geni Carcinoma.										7 months						
(c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Liver disease & cardiovascular 2° alcohol abuse																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from Jan 80 to July 17 80, that (I) (we) last saw the deceased alive on July 17 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										22c. DATE SIGNED 8.8.80						
22d. SIGNATURE Donald E. Dillon		22e. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DONALD E DILLON, M.D.		22e. ADDRESS 18111 Prince Philip Dr. OLNEY, Md. 20832														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/9/80		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood			COUNTY PG		STATE Md.				
24. FUNERAL DIRECTOR NAME Hines/Rinaldi F.H. 11800 N.H.Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR AUG 13 1980		25b. REGISTRAR'S SIGNATURE Henry Hines												
DHMH-16 20M (VRA 15, 4) 7/78																

1000 1000

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2 AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3 WITH FORM PM 3 RETAINED BY THE CHIEF MEDICAL EXAMINER. PAGE 3 SHOULD BE USED AS A URN-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN THE DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 8021311

1- FOR
STATE
REGISTRAR

1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

2a. DATE KNOWN MONTH DAY YEAR
OF ESTI-
DEATH 18 31 80 A M

3. SEX

4. RACE

5. DATE OF BIRTH
MONTH DAY YEAR6. AGE (IN YEARS
LAST BIRTHDAY)
YRS.7. IF UNDER 1 YR.
MONTHS DAYS8. IF UNDER 24 HRS.
HOURS MIN.2c. DATE
PRONOUNCED
DEAD

MONTH DAY YEAR

2b. HOUR
2d HOUR
M

Male Cauc.

9 17 27 52

YRS.

7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Virginia

7b. CITIZEN OF WHAT COUNTRY?

USA

8. MARRIED NEVER MARRIED
WIDOWED DIVORCED

9. BALTIMORE CITY OR COUNTY OF DEATH

Montgomery

2d HOUR
8 45

10. CITY OR TOWN OF DEATH

Rockville

11. FACILITY OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

402 Blanford St.

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)

Carpenter

12b. KIND OF BUSINESS
OR INDUSTRY

Construction

13. PRELIMINARY RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

14. STATE

Md.

13b. COUNTY

Montg.

13c. CITY OR TOWN

Rockville

13d. INSIDE CITY LIMITS?
YES NO

13e. STREET ADDRESS

402 Blanford St.

14. FATHER'S NAME

FIRST

MIDDLE

LAST

15. MOTHER'S MAIDEN NAME

FIRST

MIDDLE

LAST

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

(IF YES, GIVE WAR OR DATES)

Yes

16b. SOCIAL SECURITY NO.

228-28-4230

17. INFORMANT

Eva Carter

ADDRESS

Ringold, Va.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

CORONARY

THROMBOSIS

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

ACUTE

410 -

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)

CORONARY

ARTERIOSCLEROSIS

2-3 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES NO

21a. EXTERNAL CAUSE WAS

UNDERLYING OR
CONTRIBUTING CAUSE OF DEATH

21b. TIME OF INJURY

HOUR A.M.

MONTH DAY

YEAR

21d. INJURY OCCURRED

WHILE NOT WHILE AT WORK 21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)

Home

CITY OR TOWN

COUNTY

STATE

21f. LOCATION

STREET
402 BLANFORD ST ANNVILLE MONT MD

22a. I certify that I took charge of the remains described above, held an

death resulted from: Natural causes Accident Suicide Homicide Undetermined manner Autopsy Inspection Inquiry and in my opinion

22b. TITLE (SPECIFY)

Deputy

MEDICAL EXAMINER

DATE
SIGNED 8-31-80ACTUAL
SIGNATUREEXAMINER'S NAME
(TYPE OR PRINT)

Francis C. Mayle, M.D.

ADDRESS 8200 Wisconsin Ave.

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

Sept. 4, 1980

23c. NAME OF CEMETERY OR CREMATORIUM

Highland Burial Pk.

23d. LOCATION

Danville, Va.

CITY OR TOWN
COUNTY
STATE24. FUNERAL DIRECTOR
NAME

Robert A. Pumphrey Funeral

25a. DATE
ADDRESS

Homes, P.A.

25b. DATE
ADDRESS

Rockville, Md.

25c. DATE
ADDRESS

SEP 3 1980

801

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

151

11

092 8930

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN CAPITOL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR USE.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF CAPITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

1- FOR STATE #21f, per call w/
REGISTRAR F. H. 9/15/80 k. ME

Kam STATE OF MARYLAND Items 21a. Film G548 10-5-80
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 0 gal 2 1 3 1
MEDICAL EXAMINER'S CERTIFICATE OF DEATH REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			MONTH DAY YEAR			2b. HOUR		
Charles W. Schneider						<input checked="" type="checkbox"/>			8 21 1980					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS	MONTHS	DAYS	HOURS	MIN				2d. HOUR	
Male	White	Sept. 30, 1906 71	YRS.										4:50 p.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH				
Pennsylvania		U. S. A.								Montgomery County				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Takoma Park		Washington Adventist Hospital			Judge					U.S. Govt.				
13a. STATE		13b. COUNTY Prince			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Maryland		Montgomery			Georgetown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7504 Glenside Drive				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST	16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
John		P.	Schneider	Gertrude	17. INFORMANT		Herman			3704 Park Ave.				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		John Phillip Schneider Memphis, Tenn.							
No		218-34-7438												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: Blunt injury to back														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			<input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 8 21 1980			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell from tree, agonal									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home			21f. LOCATION STREET CITY OR TOWN 7504 Glenside Drive, Takoma Park, Montgomery			Prince George's County, State County, State County, State County, State						
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE		TITLE (SPECIFY)			M.D. Assistant			MEDICAL EXAMINER						
EXAMINER'S NAME (TYPE OR PRINT)		Virginia L. Dolan, M.D.			ADDRESS			DATE SIGNED 8-22-80						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL Cremation			23d. LOCATION CITY OR TOWN		COUNTY			STATE		
Cremation		8/23/1980		Cedar Hill Crematory			Suitland		Pr. Geo. Maryland					
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE									
Donald M. Stein Hebrew Memorial F.H.														
232 Carroll Street N.W. Washington, D.C.		AUG 26 1980												

negative and positive to the control

30 of 30

negative and positive to the control

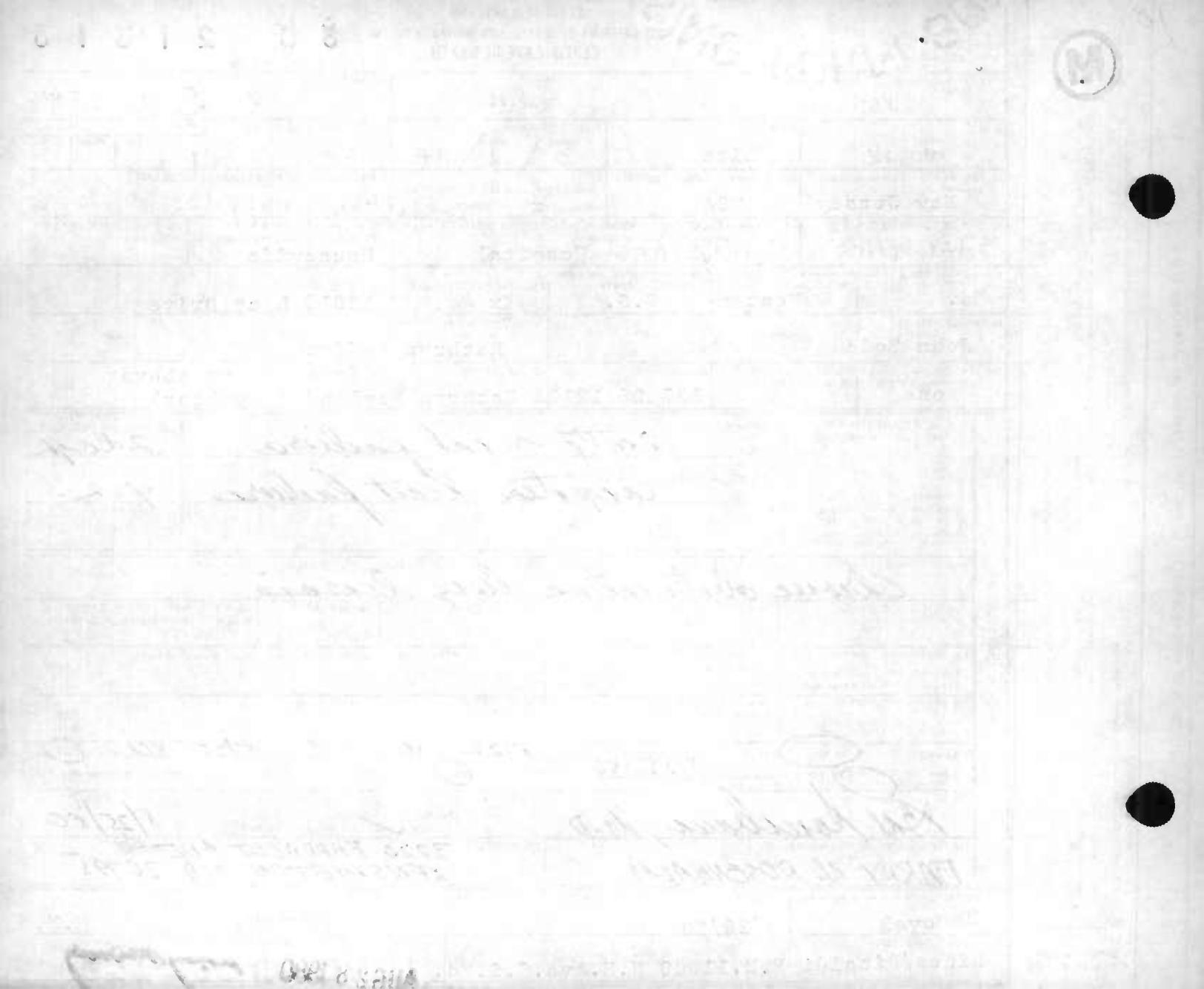
negative and positive to the control

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked on Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021313		
REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2. DATE OF DEATH			MONTH	DAY	YEAR	26. HOUR		
Kathryn			T.		Sheild	8			25	80	2:30P			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
female		White		MONTH 3	DAY 2	YEAR 94	86			MONTHS 8	YEARS 1	MONTHS 0	HOURS 0	MIN 0
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
New Jersey		USA					Montgomery Co.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Silver Spring		Holy Cross Hospital					Housewife							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS				
Md.		Mont		S.S.			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			12818 Lacy Drive				
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST				
John Todd					Kathryn Hoffman									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. ADDRESS							
None		157 26 1211A		Kathryn Newland (Daughter)			Same as above							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)). PART I. DEATH WAS CAUSED BY.												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) <u>acute renal failure</u>												2 days		
4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												(b) <u>acute renal failure</u>		
DUE TO, OR AS A CONSEQUENCE (b) <u>acute renal failure</u>												4 yrs -		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>acute renal failure</u>														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
							YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE NOT WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE	
22a. I certify that (I) this hospital attended the deceased from saw the deceased alive on <u>8/25/80</u> , and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (If we did not) view the body after death.				22b. DATE SIGNED										
22b. SIGNATURE <u>BARRY N. ROSENBAUM, M.D.</u>				DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR			STAFF PHYSICIAN	
22c. PHYSICIAN'S NAME (TYPE OR PRINT)		22d. ADDRESS		3720 FARRAGUT AVE KENSINGTON, MD 20795										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY#)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE	
Removal		8/26/80					Warwick,						N.Y.	
24. FUNERAL DIRECTOR NAME Hines/Rinaldi		ADDRESS F.H. 11800 N.H.Ave. S.S. Md.		25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE							
				AUG 28 1980										



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8021314
REG. NO.

1- STATE REGISTRAR		2a. DATE KNOWN OF DEATH ESTI- MATED		2b. MONTH DAY . YEAR	2b. HOUR M			
1. DECEASED NAME (TYPE OR PRINT)		3. SEX M ale		4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 09 15 20 59 YRS.	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Washington, D. C.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery		
10. CITY OR TOWN OF DEATH 5-4580		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hosp		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner		12b. KIND OF BUSINESS Cello-Rap Card Company		
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 200 BELTON ROAD
14. FATHER'S NAME George		15. MOTHER'S M AIDEN NAME Shuman		16. SOCIAL SECURITY NO. 579-16-5512		17. INFORMANT Mrs. Miriam Shuman		18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
18a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		18b. IMMEDIATE CAUSE (a) 185- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.		18c. DUE TO, OR AS A CONSEQUENCE OF (b) <i>Metastatic Carcinoma</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Carcinoma of Prostate</i>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 <i>None</i>								
19a. DATE OF OPERATION <i>None</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion								
TITLE (SPECIFY) <i>John D. Bogen</i> M.D. <i>Dape</i> MEDICAL EXAMINER								
DATE SIGNED <i>Aug 11, 1980</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/12/1980		23c. NAME OF CEMETERY OR CREMATORIAL Mount Lebanon Cemetery		23d. LOCATION CITY OR TOWN Adelphi, Md., Geo., Maryland		
24. FUNERAL DIRECTOR NAME Donald M. Stein		25. DATE REC'D. BY REGISTRAR 750 REGISTRAR SIGNATURE 232 Carroll Street, N. W. Washington, D. C.						
DMMH-17 (VR A15 ME (5)) 15M 7/76								

1864-1874

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												B. DEANE SHURE 3 5								
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			2. ADDRESS			3. LAST			2a. DATE OF DEATH		2b. MONTH		2c. DAY		2d. YEAR		2e. HOUR	
		<u>R. Deane</u>						<u>Shure</u>			8 11 80		11 18		AM					
3. SEX		4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS							
<u>Male</u>		<u>White</u>			MONTH <u>5</u> DAY <u>31</u> YEAR <u>1985</u>			95			MONTHS <u>95</u>		DAYS <u>0</u>		HOURS <u>0</u>		MIN <u>0</u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY		
<u>Penna</u>		<u>U.S.A.</u>						<u>Montgomery Co.</u>			<u>Montgomery Co.</u>		<u>Ashbury-Rehman Wilson HCC</u>			<u>Minister of music</u>				
13a. STATE		13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		13f. ADDRESS			14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		
<u>MD</u>		<u>Mont.</u>			<u>Takoma Park</u>			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			<u>8 Pine Avenue</u>		<u>B-</u>			<u>First</u>		<u>Mary</u>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			19. ADDRESS		20. ADDRESS			21. MEDICAL CERTIFICATION		22. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
(b) <u>NO</u>		<u>579-44-1468</u>			<u>RALPH G. SHURE, 100 NARRETTIN DR S. S. MD</u>															
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4409</u>		DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerosis</u>			DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																				
21a. DATE OF OPERATION		21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			21d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			22. DATE SIGNED				
21e. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21f. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21g. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21, PART 1 OR PART 2)											8-12-88				
21h. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21i. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21j. LOCATION STREET			21k. CITY OR TOWN			21l. COUNTY		21m. STATE							
21n. I certify that (i) this hospital attended the deceased from <u>7-19 19 80</u> to <u>8-11 19 80</u> , that (ii) (we) last saw the deceased alive on <u>8-11 19 80</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (ii) (we) did (did not) view the body after death.																				
22a. SIGNATURE <u>Michael A. Bolognesi</u>		22b. DEGREE			22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED												
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Michael A. Bolognesi</u>		22f. ADDRESS <u>19261 Montgomery Village Rd 6a, Bethesda, Md. 20760</u>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Aug. 14, 1980</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Rock Creek Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Washington</u>			23e. COUNTY		23f. STATE							
24. FUNERAL DIRECTOR NAME <u>John W. Kelly</u>		ADDRESS <u>251 Carroll St. N.W.</u>			25. DATE REC'D. BY REGISTRAR/M. REGISTRAR <u>AUG 18 1980</u>															

DEPT. OF

REVIEW

2 give here

2 Monday

11

SV 12 26 Voluminous notes to read

12.51-8

Oct 2 1967

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be despatched for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or either traumatic event, the medical examiner must be paged at once.

MEDICAL CERTIFICATION

1. DECEASED NAME				FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
Lillie				Mo	4	Simmons	8	13	80	6:15	P M	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female		Caucasian		MONTH	DAY	YEAR	79	YRS.	MONTHS	DAYS	HOURS	MIN
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. USUAL OCCUPATION		
Columbia N.C.		USA					Montgomery County			11. KIND OF BUSINESS OR INDUSTRY		
12. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. CITY OR TOWN			12b. STREET ADDRESS			12c. ADDRESS		
Gaithersburg		Wilson Health Care Center		Rockville			100 Argyle Street			13001 Glen Mill Road		
14. STATE		13a. COUNTY		13b. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. LAST NAME		
Maryland		Montgomery		Rockville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			DAVENPORT		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			19. ADDRESS		
NO		579-42-5623		Dennis C. Simmons			5 min			Rockville, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)												
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)												
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Arteriosclerosis 10 years												
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized Arteriosclerosis 10 years												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Inactive pulmonary TB & fibrothorax, Cerebral arteriosclerosis												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR PM 19		21c. HOW INJURY OCCURRED ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (1) this hospital attended the deceased from June 30, 1980, to Aug 13, 1980, that (2) (we) last saw the deceased alive on July 16, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) did not view the body after death.												
22b. SIGNATURE		22c. DEGREE		22d. ADDRESS			22e. DATE SIGNED					
James R. Moore Jr.		MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						8-14-80		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE
Burial		8/16/80		Parklawn Mem. Park			Rockville			Montgomery		Md.
24. FUNERAL DIRECTOR		NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
Tyson Wheeler Funeral Home, Inc.		1331 Rockville Pike		Rockville, Md.			AUG 21 1980			Amy McHenry		

— 2 —

20

26

Digitized by srujanika@gmail.com

TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may

be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filled within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021317	
1. FOR STATE REGISTRAR			REG. NO.										
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
FRANK Joseph SIRATZ						August 7 1980			5:40 P.M.				
3. SEX Male			4. RACE Caucasian			5. DATE OF BIRTH MONTH DAY YEAR July 20, 1894			6. AGE (IN YEARS LAST BIRTHDAY) 86				
7a. BIRTHPLACE COUNTRY Austria			7b. CITIZEN OF WHAT COUNTRY? United States			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County				
10. CITY OR TOWN OF DEATH Rockville			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rockville Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist			12b. KIND OF BUSINESS OR INDUSTRY S.K.F. Co.				
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>				
14. FATHER'S NAME FIRST MIDDLE LAST N/A			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emily Bolan			16. STREET ADDRESS 19026 Coltfield Court							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 164-09-4210			17. INFORMANT Emily Siratz Noto			ADDRESS Same as item #13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism 4151 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cerebral Vascular accident												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Quinsy	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (we) attended the deceased from <u>Sept 18</u> , 19 <u>80</u> , to <u>July 8</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>9 July</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED 8/7/80	
22b. SIGNATURE John G. Fawcett, M.D.			22c. DEGREE			ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Fawcett, M.D.			22e. ADDRESS 16610 Sugarland Rd. Boyds, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Aug. 11, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Sunset Mem. Pk.			23d. LOCATION CITY OR TOWN Festerville			23e. COUNTY PA.	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						25a. DATE REC'D. BY REGISTRAR AUG 8 1980			25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey				

changes

in the

leads

in the

other directions

and the

other

directions

are to be given

in the

other

directions

and the other

directions

and the other

directions

and the other

directions

and the other

directions

and the other

directions

and the other

directions

and the other

directions

and the other

directions

and the other

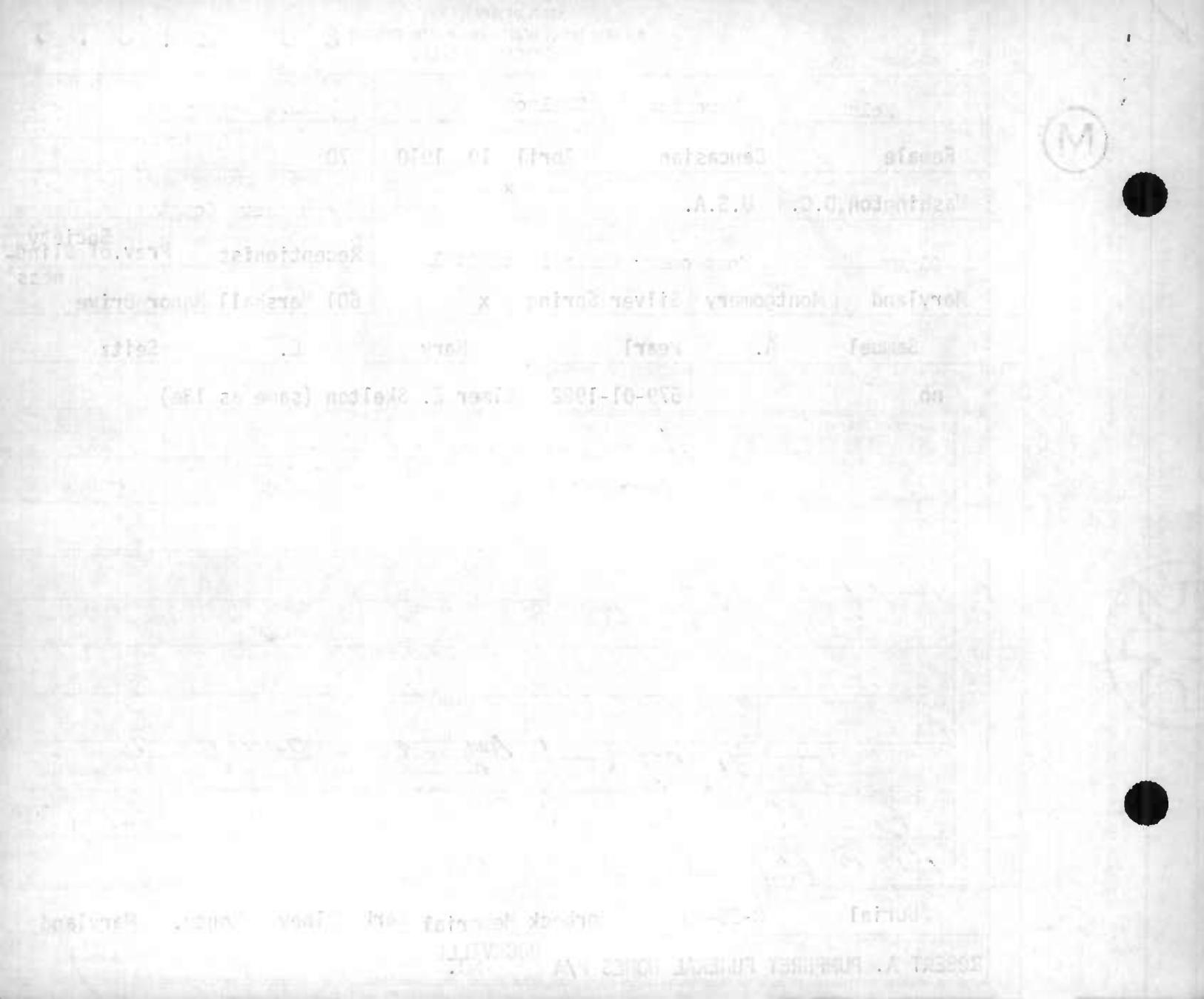
directions

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 3 1 8								
												REG. NO.								
1 - FOR STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR					
			Helen Veronica Skelton						August 22 1980						8:50 a.m.					
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS HOURS MIN					
Female			Caucasian			MONTH April DAY 10 YEAR 1910			70											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Washington, D.C.			U.S.A.						Montgomery County											
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY											
Olney			Montgomery General Hospital			Receptionist			Society Prev. of Blinn- ness											
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS								
Maryland			Montgomery			Silver Spring			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			601 Marshall Manor Drive								
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
Samuel A. Pearl			Mary E. Seitz			no			579-01-1982			Elmer E. Skelton (same as 13e)								
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												3 hrs								
DUE TO, OR AS A CONSEQUENCE OF (b)												5 mo								
DUE TO, OR AS A CONSEQUENCE OF (c)																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a Renal failure, hypotension																				
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)														
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE														
22a. I certify that (I) (this hospital) attended the deceased from <u>21 Aug 80</u> to <u>22 Aug 19 80</u> , that (I) (we) last saw the deceased alive on <u>21 Aug 19 80</u> , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																				
22b. SIGNATURE Donald E. Dillon, M.D.												22c. DATE SIGNED 22 Aug 80								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 1811 Pr. Philip Dr. Olney 20832			22e. ADDRESS Donald E. Dillon, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-25-80			23c. NAME OF CEMETERY OR CREMATORIUM Norbeck Memorial Park			23d. LOCATION CITY OR TOWN Olney			COUNTY Montgomery			STATE Maryland					
24. FUNERAL DIRECTOR NAME ROBERT A. PUMPHREY FUNERAL HOMES P/A			ADDRESS ROCKVILLE MD.			25a. DATE REC'D. BY REGISTRAR AUG 28 1981			25b. REGISTRAR'S SIGNATURE Robert McElroy											
BP																				
DHMH - 16 50M 1/76 (VR A 15 (4))																				

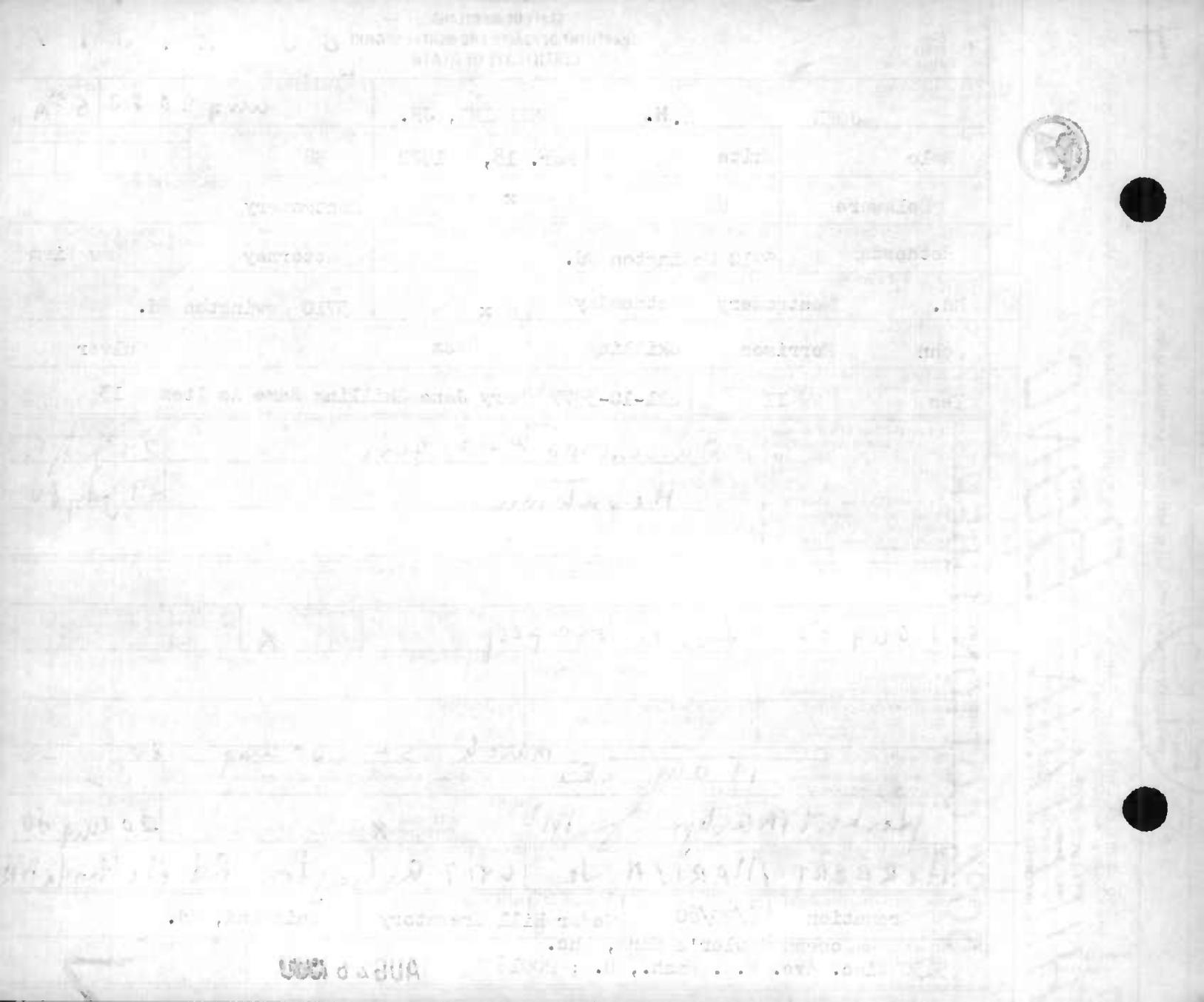


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021319
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	REG. NO.
JOHN M. SKILLING, JR.						Aug 20 80			80	20	80	26 HOUR 5 A.M.
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS	
Male		White	Mar. 18, 1922			58			MONTHS	DAYS	HOURS	MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH				
Delaware		US			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			Montgomery				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Bethesda		5710 Newington Rd.			Attorney			Law Firm				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			
Md.		Montgomery	Bethesda			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			5710 Newington Rd.			
14. FATHER'S NAME		FIRST	MIDDLE	Skilling	15. MOTHER'S MAIDEN NAME			16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
John		Morrison			Bess			29 July 80				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			29 July 80				
Yes		WW II			221-10-3977			Mary Jane Skilling Same As Item # 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Sarcinoma tosas, gal</i>												
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Hepatoma</i>												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
1 Aug 86		Liver biopsy			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (We) attended the deceased from <i>March 19 52</i> to <i>20 Aug 19 80</i> , that (I) (We) last saw the deceased alive on <i>19 Aug 19 80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (did) (did not) view the body after death.												
22b. SIGNATURE		<i>Herbert Martyn Jr</i>			DEGREE			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		HERBERT MARTYN Jr			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			20 Aug 80				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE				
Cremation		8/20/80			Cedar Hill Crematory			Suitland, Md.				
24. FUNERAL DIRECTOR		Joseph Gawler's Sons, Inc.			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
NAME ADDRESS		5130 Wisc. Ave. N.W. Wash., D.C.; 20016						AUG 6 1980				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021320							
												REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
HELEN			H.						SMITH			8/13/80						11:19 P. M.	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.					
FEMALE			CAUC.			MONTH 9 DAY 12 YEAR 92			27			MONTHS		DAYS		HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH										
Washington, DC			U.S.A.						Montgomery County MD.										
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			901 Arcada Ave.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Housewife			12b. KIND OF BUSINESS OR INDUSTRY				
Wheaton			UNIVERSITY NURSING HOME												Home				
13a. STATE Maryland			13b. COUNTY Montgomery			13c. CITY OR TOWN Silver Spring			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 12707 Spring Tree Drive							
14. FATHER'S NAME FIRST James			MIDDLE W.			LAST Hunter			15. MOTHER'S MAIDEN NAME FIRST Adeline			MIDDLE			LAST Mercer				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. INFORMANT			17. ADDRESS 12707 Spring Tree Drive, Silver Spring, Md.										
No			None			213-48-1907J1			Albert J. Smith										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE PNEUMONIA 3 weeks</u>																			
5188 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.												DUE TO, OR AS A CONSEQUENCE OF (b) <u>Secondary to chronic lung disease 10 yrs.</u>							
DUE TO, OR AS A CONSEQUENCE OF (c) _____																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 8/13/80 to 8/13/80, that (I) (he) last saw the deceased alive on 8/13/80, and that in (my) (his) opinion death occurred on the date and hour and from the causes stated above. (I) (he) (did not) view the body after death.																			
22b. SIGNATURE Myron L. Lenkin						DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/13/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS 2309 Shorefield Rd., Wheaton, Md. 20902																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8/16/80			23c. NAME OF CEMETERY OR CREMATORIAL Rock Creek Cemetery			23d. LOCATION CITY OR TOWN Washington			COUNTY STATE							
24. FUNERAL DIRECTOR NAME Hines/Rinaldi Funeral Home			ADDRESS 11800 N.H. Ave Silver Spring, Md.			25a. DATE REC'D. BY REGISTRAR AUG 18 1980			25b. REGISTRAR'S SIGNATURE Hines/Rinaldi										

1000-0100A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

1 - STATE REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH80 21321
REG. NO.
Aug. 28, 1980
2b. HOUR
5:00 AM

1 DECEASED NAME (TYPE OR PRINT)			FIRST JOSEPH	MIDDLE A.	LAST SMITH	2a. DATE OF DEATH MONTH Sept. 23, 1895	MONTH DAY YEAR	2b. DAY YEAR	2b. HOUR 5:00 AM						
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH Sept. 23, 1895		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pa.		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery		10. CITY OR TOWN OF DEATH Chevy Chase		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 7710 Meadow Lane		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Buyer		12b. KIND OF BUSINESS OR INDUSTRY Retail	
13a. STATE Md.		13b. COUNTY Montgomery		13c. CITY OR TOWN Chevy Chase		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 7710 Meadow Lane							
14. FATHER'S NAME Joseph		MIDDLE FIRST		LAST Smith		15. MOTHER'S MAIDEN NAME Ann		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes.		16b. SOCIAL SECURITY NO. W W I		17. INFORMANT Carl E. Smith Rt. # 1 Box 29F Valley View		18. CAUSE OF DEATH (Enter only one cause per line for 1(a), 1(b), and 1(c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any. DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Coronary DUE TO, OR AS A CONSEQUENCE OF (c) Occlusion - APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19. MEDICAL CERTIFICATION		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Malnutrition													
19a. DATE OF OPERATION 1972		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Pacemaker installed		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IN EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Alexander S. Russell M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/28/80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alexander S. Russell		22e. ADDRESS 106 Irving St. Wash. D.C.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 8/28/80		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Crematory		23d. LOCATION CITY OR TOWN Suitland, Md.		COUNTY		STATE					
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR SEP 2 1980		25b. REGISTRAR'S SIGNATURE Lillian McCreary									

M

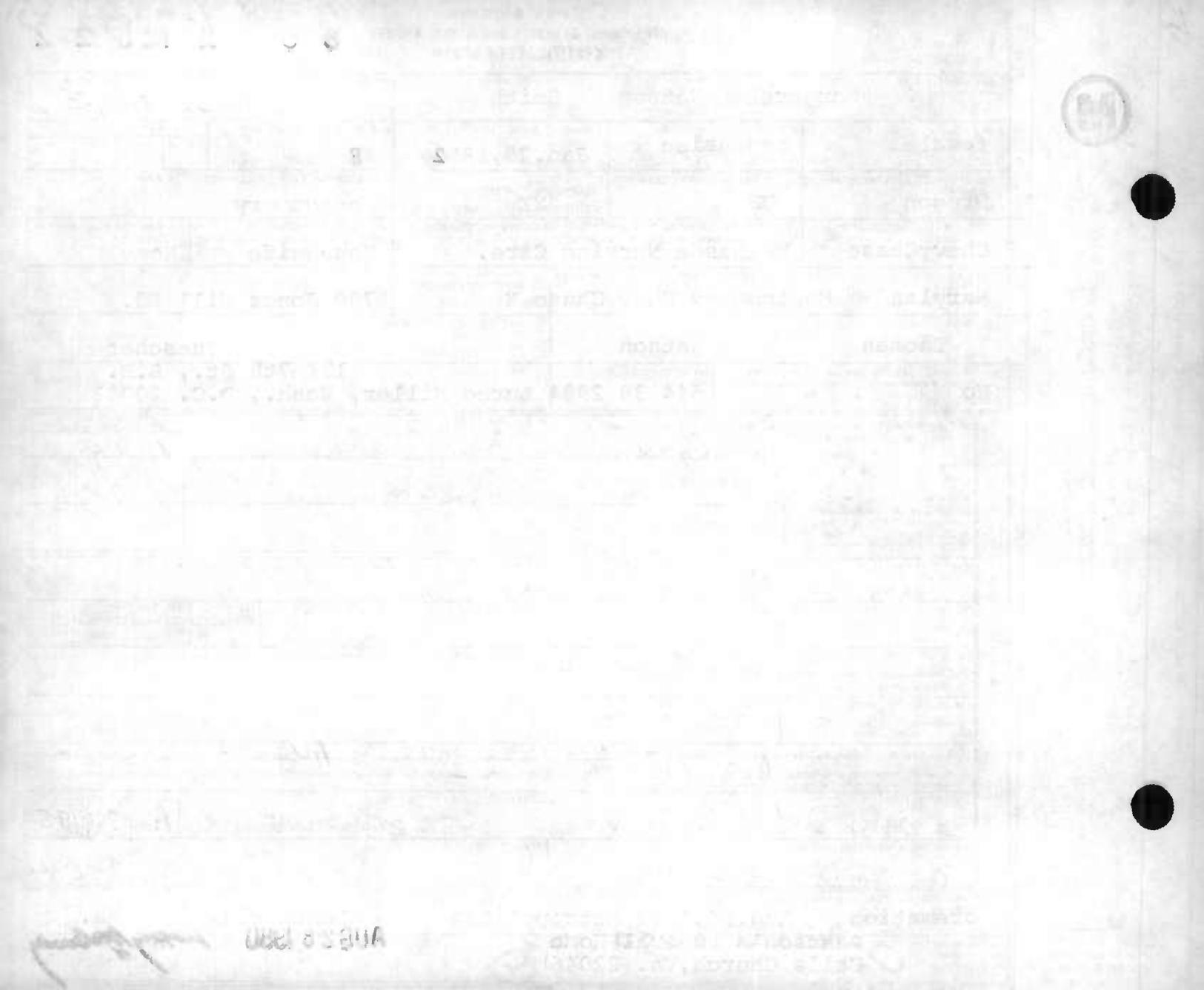
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-cremation permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours and with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8021322					
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Margaret Watson Smith			8 22 80		155 PM										
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS					
female		caucasian		MONTH DAY YEAR		88		MONTHS DAYS		MONTHS HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		10. CITY OR TOWN OF DEATH							
Oregon		USA				Montgomery		ChevyChase							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Bethesda Nursing Ctre.				Housewife				Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		14. FATHER'S NAME					
Maryland		Montgomery		ChevyChase		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		8700 Jones Mill Rd.		FIRST MIDDLE LAST					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <input type="checkbox"/> NO				16b. SOCIAL SECURITY NO.				17. INFORMANT				124. ADDRESS			
				544 38 2984				Luree Miller, Wash., D.C. 20003				10 St., S.E.			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Cerebral thrombosis and Coma.</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4340 <u>10 Days</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>Cerebral arteriosclerosis</u> or one yr. (c)															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>Terminal Pulmonary Congestion</u>															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____											
22a. I certify that (1) this hospital attended the deceased from <u>Nov. 14</u> , 19 <u>78</u> , to <u>Aug. 22</u> , 19 <u>80</u> , that (1) (we) lost saw the deceased alive on <u>August 20</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.															
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22c. DATE SIGNED			
Warren D. Brill, M.D.												Aug. 22, 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS				2000 N St N.W. Wash. D.C. 20034									
Warren D. Brill, M.D.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN _____ COUNTY _____ STATE _____									
cremation		Aug. 24, 1980		Metropolitan		Alexandria,		Va.							
24. FUNERAL DIRECTOR NAME		ADDRESS				25. DATE RECEIVED BY DEPT. OF HEALTH AND MENTAL HYGIENE REGISTRATION SECTION									
Pearson's Funeral Home Falls Church, Va. 22046						AUG. 24, 1980									

BP



Chandler J. John Clegg
4
TO HOSPITAL OR ATTENDING PHYSICIAN: The death certificate requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

4
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 2 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021323	
REG. NO.													
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)				FIRST Marie	MIDDLE D.	LAST Smith	2a. DATE OF DEATH	MONTH Aug.	DAY 14, 1980	YEAR	2b. HOUR 1230PM	M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH Oct.	DAY 31	YEAR 1899	6. AGE (IN YEARS LAST BIRTHDAY) 80	YRS.	7. IF UNDER 1 YEAR MONTHS 0	8. IF UNDER 24 HRS HOURS 0	9. IF UNDER 24 HRS MIN 0				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			MD.					
10. CITY OR TOWN OF DEATH Silver Spring	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland	13b. COUNTY Montgomery	13c. CITY OR TOWN Silver Spring	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 7925 Chicago Avenue									
14. FATHER'S NAME FIRST John	MIDDLE Manuel	LAST	15. MOTHER'S MAIDEN NAME Sallie	16. ADDRESS 4120 Doveville Lane									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO	16b. SOCIAL SECURITY NO. 577-03-8431	17. INFORMANT Son Charles G. Dodd	18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min										
18. CAUSE OF DEATH (Enter only one cause per line for 10a, 1b, and 1c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Aspiration</u> 5609 DUE TO, OR AS A CONSEQUENCE OF (b) <u>INTESTINAL OBSTRUCTION</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (c)													
2 hrs													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Colostomy													
19a. MEDICAL CERTIFICATION DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE								
22a. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> , 19 <u>80</u> , to <u>11/7</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>11/6</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>John Clegg</i> DEGREE													
ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> 22c. DATE SIGNED <i>John Clegg</i> AUG 18 1980													
22e. ADDRESS 10620 6a. Av. 55nd													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 8/16/80	23c. NAME OF CEMETERY OR CREMATORIUM CEDAR HILL CEMETERY	23d. LOCATION CITY OR TOWN SUITLAND	23e. COUNTY PRINCE GEORGE	23f. STATE MD.								
24. FUNERAL DIRECTOR FRANCIS J. COLLINS NAME 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901	25a. DATE REC'D. BY REC'D. BY AUG 18 1980				25b. REC'D. BY <i>John Clegg</i>								

1880-1881

ଓঁ শশী পাতো

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 3 2 4						
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Ethel S						Snyder			8 27 80					450	A.M.	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		White		Month Day Year			66			MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Penn.		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery			MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY		
S.S.		Holy Cross Hospital								Clerk NADA				Retired		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS						
Florida		Orange		Lake Alfred			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			250 Itasca Ave.						
14. FATHER'S NAME		FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME											
John Steffen					Roxie											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO			17. INFORMANT			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
None		168 12 7645			Same as above			Howard Snyder (Husband)			5 years.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)																
PART I. DEATH WAS CAUSED BY																
IMMEDIATE CAUSE (a) <i>Hepatotoxic carcinoma</i>																
1749 DUE TO, OR AS A CONSEQUENCE OF																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																
(b) <i>Adenocarcinoma of breast</i>																
DUE TO, OR AS A CONSEQUENCE OF																
(c) _____																
14 years																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED								20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>June 19 80</i> to <i>8/27 1980</i> , that (I) (we) last saw the deceased alive on <i>8/26 1980</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																
22b. SIGNATURE <i>C. Lennard Gold</i> DEGREE																
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																
22c. DATE SIGNED <i>8/27/80</i>																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS														
C. Lennard Gold		8630 Fenton St. S.S.Md.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
Burial		8/30/80			Ft. Lincoln Cemetery			Brentwood		PG		Md.				
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. <i>Hines/Rinaldi F.H. 11800 N.H.Ave. S.S.Md.</i>			25b. <i>8630 Fenton St. S.S.Md.</i>		25c. <i>PG</i>		25d. <i>Md.</i>				
DHMH-16 25M (VRA 15, 4) 1/79																

1000 300

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

8 0 2 1 3 2 5
REG. NO.

1. FOR STATE REGISTRAR			2a. DATE KNOWN OF ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR						2b. HOUR MONTH DAY YEAR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			8/15 1980			M		
Margaret Agnes Sollers											
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN	
Female		White		Aug. 31, 1894		85 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?						8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Washington, D.C.		USA								Montgomery County MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Rockville		146 39 Bauer Drive, #218						Operator		Eng. & Print. Bus.	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME	
Maryland		Montgomery		Rockville				146 39 Bauer Drive, #218		FIRST MIDDLE LAST	
William		A.		Wilding		15. MOTHER'S MAIDEN NAME		Mary		F. O'Dea	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.						17. INFORMANT		16331 Tone Drive	
No		579-48-2174						Brother		Anthony W. Wilding Bethesda, Maryland	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial disease.</u> Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) (c)											
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (b). None											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?			
None								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			None			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> and in my opinion											
22b. TITLE (SPECIFY) John S. Rogers, M.D. Deputy, MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) ADDRESS 1919 Sepinary Road 500 University Blvd., W. Silver Spring, Montgomery, Md.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL CITY OR TOWN				23d. LOCATION CITY OR TOWN		COUNTY STATE	
Burial		Aug. 18, 1980		Mt. Olivet Cemetery				Washington, D. C.			
24. FUNERAL DIRECTOR NAME		Francis J. Collins						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
500 University Blvd., W.		Silver Spring, Md.						AUG 18 1980		John S. Rogers	

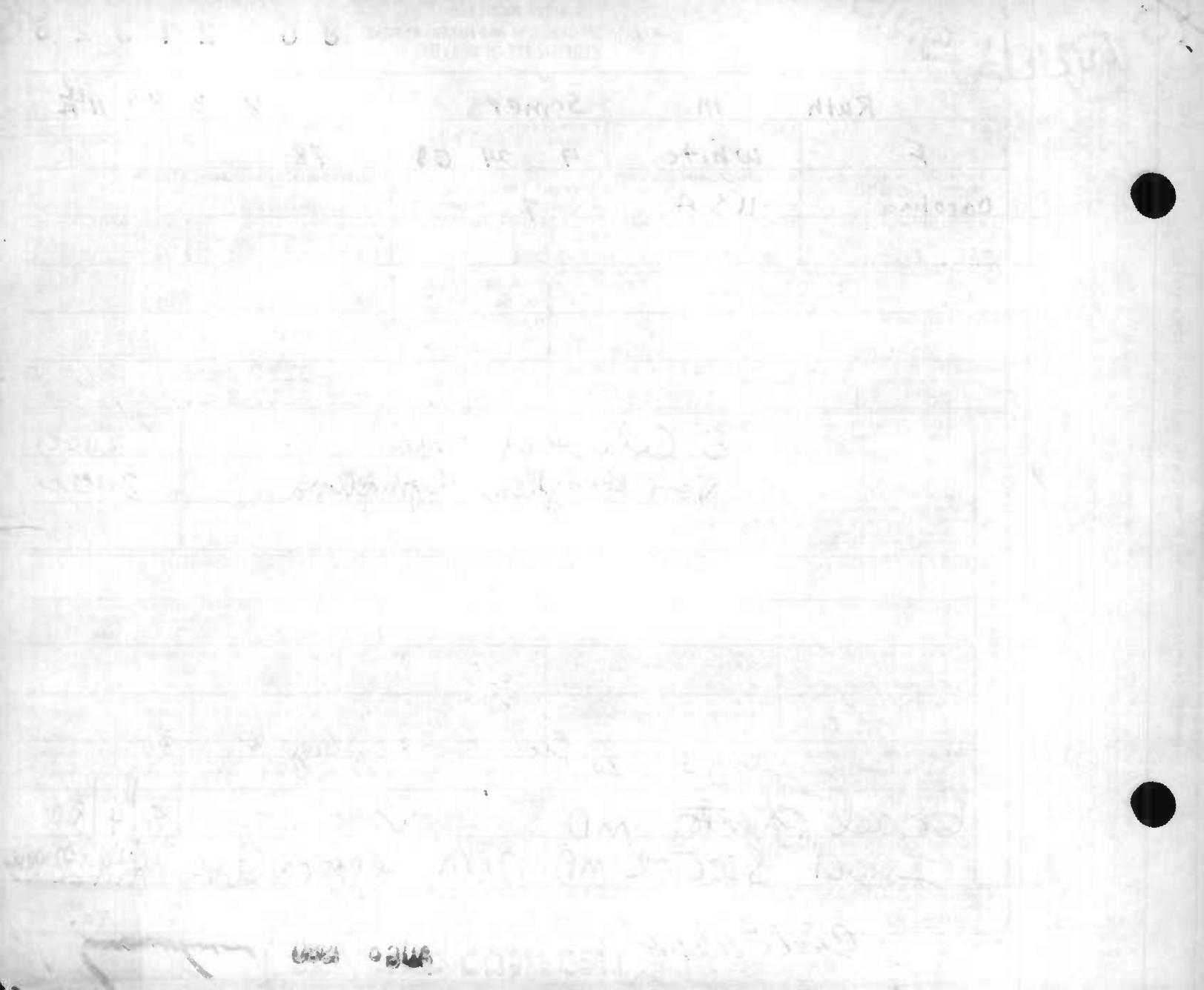
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR USE. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

3 TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021326			
												REG. NO.			
1 - STATE REGISTRAR			1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
Ruth m Somers									8 3 80			11/4 AM			
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
F		White		9 24 1901			78X 79 YRS			MONTHS DAYS		HOURS MIN			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
South Carolina		USA					Montgomery								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY								
Sil. Spr.		Holy Cross Hospital		Retired			U. S. Government								
13a STATE Md.		13b COUNTY Montgomery		13c CITY OR TOWN Sil. Spr.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS 2114 Cascade Road					
14 FATHER'S NAME FIRST Robert		MIDDLE W.		LAST Wynne			15 MOTHER'S MAIDEN NAME FIRST Lucy			MIDDLE		LAST Williams			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO		17 INFORMANT			18 ADDRESS 2114 Cascade Drive Bd. Gary D. Somers Sil. Spr., Md.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks					
No		578-16-8289A												2 years	
18 CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2028 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) E. Coli Septicemia (c) Non Hodgkin's Lymphoma															
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 18															
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from <u>Aug 3</u> 1980, to <u>Dec 19 78</u> to <u>Aug 3 1980</u> , that (I) (we) lost sow the deceased alive on <u>Aug 3 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) see the body after death.															
22b SIGNATURE Israel Spector MD		22c DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d DATE SIGNED 8/4/80							
22d PHYSICIAN'S NAME (TYPE OR PRINT) Israel Spector MD		22e ADDRESS 12001 Ferrara Ave. Wheaton MD 20906													
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 8/6/80			23c NAME OF CEMETERY OR CREMATORIUM Somers Cemetery			23d LOCATION CITY OR TOWN Luray		COUNTY		STATE Va.			
24 FUNERAL DIRECTOR NAME Warner E. Pumphrey, Inc.		ADDRESS 8434 Ga. Ave Sil. Spr., Md.			25a DATE REC'D. BY REGISTRAR AUG 6 1980			25b REGISTRAR SIGNATURE							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8 0 2 1 3 2 7			
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR
WILLIAM		E.				STAIGER		8		6	80		11/5 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Male		White		MONTH 7 DAY 3 YEAR 1902		78		MONTHS		DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		9. IF UNDER 1 YEAR		8. IF UNDER 24 HRS			
Penn.		U. S. A.				MONTGOMERY		MONTHS		DAYS			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION TYPE OF WORK FOR MOST OF WORKING LIFE		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda		Suburban Hospital						Retired		Distilled Spirits			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		MD. Council of U. S.			
				Wash., D. C.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		6112 Utah Avenue, N. W.					
14. FATHER'S NAME		FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME					
Julius		Peter		Staiger		Mary							
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		18. ADDRESS		19. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		579-24-3547A		Lee W. Cowan		1120 Conn. Ave., N.W. Washington, D. C.		2 d.					

18. CAUSE OF DEATH (Enter only one cause per line for 1a), (1b), and (1c).
PART I DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) Cerebral vascular accident

436-

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause (b).

DUE TO, OR AS A CONSEQUENCE OF

(b) Arterio Sclerotic Cerebral Vascular disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

aspiration pneumonia, cirrhosis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)
--	--	--

21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
--	--	-------------------------	--------------	--------	-------

22a. I certify that (I) (this hospital) attended the deceased from 5/80, 1919, to 8/5, 1980, that (I) (we) last saw the deceased alive on 8/5/80, 1919, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
Jeremy V. Cooke MD			8/8/80

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
Jeremy V. Cooke	
10400 Conn Ave. Kensington Md.	

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	8/9/80	Ft. Lincoln Cem.	Brentwood	Maryland	

24. FUNERAL DIRECTOR NAME	ADDRESS	25r. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Warner E. Pumphrey, Inc.	8434 Ga. Ave.	Sil. Spr., Md.	Aug 15 1980

b5

Business and Social Services

and Economic Development

Business and Economic Services

b2

Business and Economic Services
Planning and Economic Development

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, Cremation, or Removal.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												8021328	REG. NO.				
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)									2a. DATE KNOWN OF ESTI- DEATH MATED					
			Louis Bernard Sterne									Aug 7 1980					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2b. DATE PRONOUNCED DEAD			
M			W			Oct 07 1907		72 yrs.						Aug 7 1980			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. BALTIMORE CITY OR COUNTY OF DEATH								
WASH D.C.			USA			<input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED			Montgomery								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Tak Park			Chest Adventist Hosp									SALESMAN - Wholesale Liquor			MD.		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
MD			Montgomery			Silver Spring			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			505 Thayer Ave, Ag 8501					
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST					
LOUIS						STERNE			BELLE E. MANUEL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			SAME AS					
No			578-07-2005A			DOROTHY M. STERNE			ITEMS 13								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
IMMEDIATE CAUSE (a) Acute myocardial infi Due to, or as a consequence of Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.																	
(b) Chronic myocardial infi Due to, or as a consequence of																	
(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?												20. AUTOPSY?		
None															<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															TITLE (SPECIFY)		
ACTUAL SIGNATURE: <i>John S. Rogers</i>															M.D. P.G. MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) JOHN S. ROGERS															ADDRESS: 1919 SEMINARY Rd. S.S. M.D.		
23a. BURIAL, CREMATION, REMOVAL (IF APPLICABLE)			23b. DATE 8/12/80			23c. NAME OF CEMETERY OR CREMATORIAL GEORGE WASHINGTON			23d. LOCATION CITY OR TOWN ADELPHI - P.G. MD								
24. FUNERAL DIRECTOR NAME W. W. CHAMBERS CO.			ADDRESS SILVER SPRING MARYLAND			25a. DATE REC'D. BY REGISTRY AUG 13 1980			25b. REGISTRY'S SIGNATURE <i>John S. Rogers</i>								
DHMH - 17 (VR A15 ME (5)) 15M 7/77																	

600-1-2000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 21329						
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
MAE									STONESTREET			8	8	80	316	A M		
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH Sept. 8 1903			DAY			6. AGE (IN YEARS LAST BIRTHDAY) 76			7. IF UNDER 1 YEAR MONTHS YRS		8. IF UNDER 24 HRS MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.									9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY			MD.			
10. CITY OR TOWN OF DEATH BETHESDA			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SUBURBAN HOSPITAL									12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland			13b. COUNTY Montg.			13c. CITY OR TOWN Barnesville			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Barnesville Rd.						
14. FATHER'S NAME John			15. MOTHER'S MAIDEN NAME Montgomery									16. ADDRESS Joseph Stonestreet			Nite			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO 214-36-3721			17. INFORMANT									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Immediate			
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			Cardiac Arrhythmia															
492- Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema												Year			
			DUE TO, OR AS A CONSEQUENCE OF (c) Chronic Obstructive Lung Disease												Years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION None			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) (this hospital) attended the deceased from 117 19 78 to 8/8 19 80, that (I) (we) last saw the deceased alive on 8/7 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE Joel Schulman			DEGREE												22c. DATE SIGNED 8/8/80			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joel Schulman			22e. ADDRESS 9410 Old Georgetown Road															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/11/80			23c. NAME OF CEMETERY OR CREMATORIAL Monocacy Cemetery			23d. LOCATION CITY OR TOWN Barnesville			COUNTY			STATE Md.			
24. FUNERAL DIRECTOR NAME W.C. Holt Barnesville Rd.			ADDRESS			25a. DATE REC'D. BY REGISTRAR Aug 15 1980			25b. REGISTRATION NUMBER									

05. 04. 2018 07:00 AM

الحمد لله رب العالمين والصلوة والسلام على سيدنا وآله وآل بيته وآل بيته الحرام
لهم آمين

لهم آمين

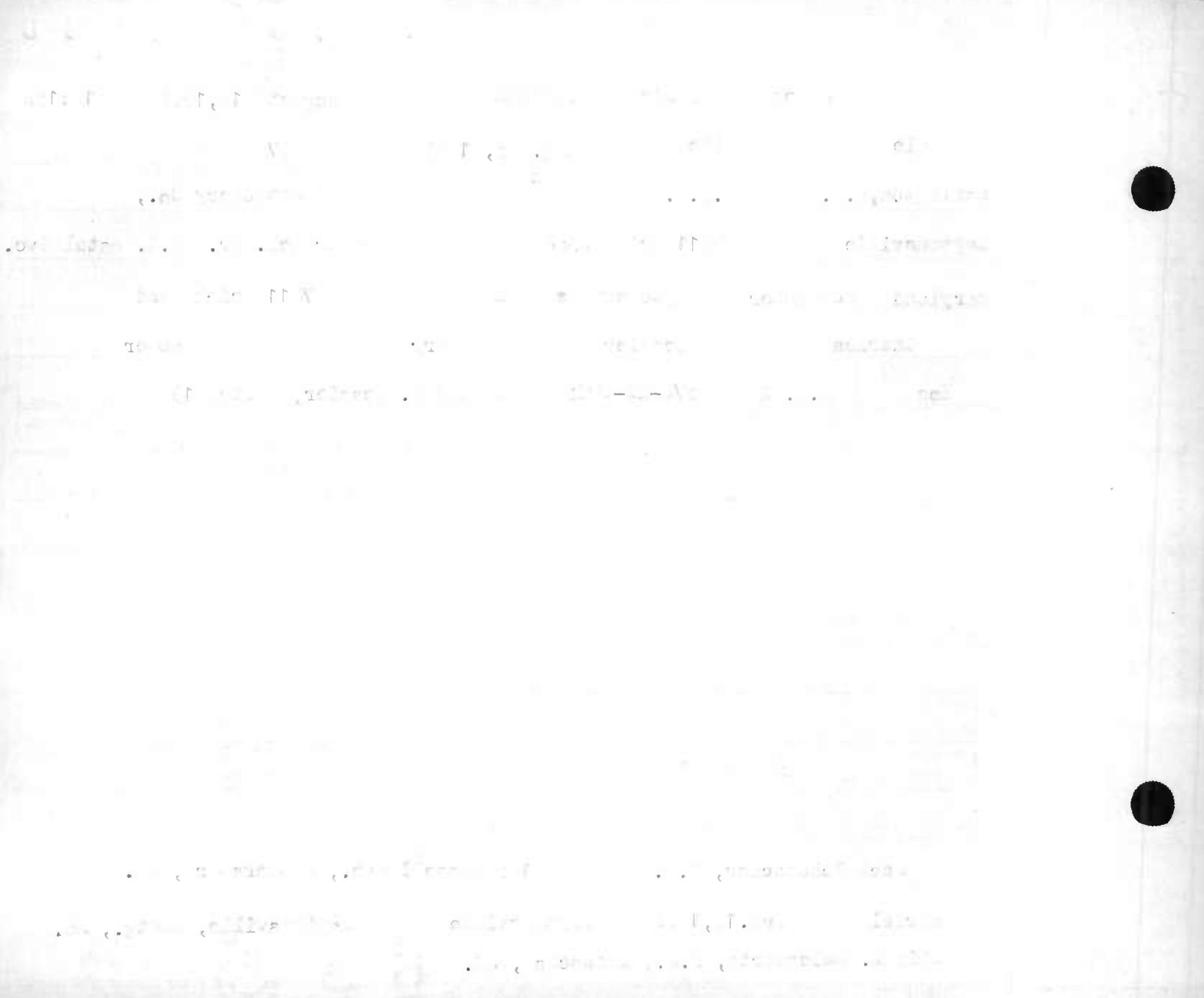
لهم آمين

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of the death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 3 3 0					
											REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
James			Louis			TESSIER						August	16, 1980			10:15A	
3. SEX			4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)	# UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White			MONTH DAY YEAR						57	MONTHS	YEARS	MONTHS	DAYS	HOURLY MIN.
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b CITIZEN OF WHAT COUNTRY?			8. MARRIED MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington, D.C.			U.S.A.			Aug. 25, 1922						Montgomery Co.,					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY					
Laytonsville			7011 Brink Road			Labor Rel. Mgr.						J.S. Postal Svc.					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Montgomery			Laytonsville			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			7011 Brink Road					
14. FATHER'S NAME FIRST			MIDDLE			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST					
Charles						Mary						Power					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS								
Yes			W.W. 2			578-22-6025			Dorothy W. Tessier, Item 13								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
IMMEDIATE CAUSE (1a) 1539 Conditions, if any, which gave rise to immediate cause (1a), stating the underlying cause, if any												Metastatic Adenocarcinoma ? Two primary sites Adenocarcinoma Colon 4 years					
DUE TO, OR AS A CONSEQUENCE OF (1b) Adenocarcinoma Colon DUE TO, OR AS A CONSEQUENCE OF (1c) Prostate Adeno carcinoma ? ?																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION 19-20-76 7-16-80			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma Carcinoma			19c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE				
22a. I certify that (1) (this hospital) attended the deceased from 19 77 to 8-16-80, that (1) (was) last saw the deceased alive on 8-15-80 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE Jack Schumacher M.D.												22c. DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			22f. DATE SIGNED											
Jack Schumacher, M.D.			105 Russell Ave., Gaithersburg, Md.			8-17-80											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY	STATE				
Burial			Aug. 18, 1980			Laytonsville			Laytonsville, Montg., Md.								
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE								
Olin L. Molesworth, P.A., Damascus						AUG 20 1980			Larry McCreary								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021331	
REG. NO.													
1. FOR STATE REGISTRAR			1. DECEASED NAME [TYPE OR PRINT]				FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
			AGNESE D. THOMAS							8 12 80		21:49 M	
3. SEX female			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE [IN YEARS LAST BIRTHDAY]			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
						July 14, 1898			82 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY MD.				
Md			USA										
10. CITY OR TOWN OF DEATH ROCKVILLE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION [TYPE OF WORK FOR MOST OF WORKING LIFE]			12b. KIND OF BUSINESS OR INDUSTRY				
			SHADY GROVE ADVENTIST HOSP						Housewife			Home	
13a. STATE Md			13b. COUNTY Montgomery		13c. CITY OR TOWN Gaithersburg		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 403 Russell ave				
14. FATHER'S NAME FIRST MIDDLE LAST Marion F Duckett			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gabriella A Duval										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO. 577 22 1413A			17. INFORMANT Janet W Pugh San Francisco, California							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			acute myocardial infarction						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hr.				
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease										
			DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (s) (h) (his hospital) attended the deceased from about Jan 19 78 to 8/12/1980, that (s) (h) (we) lost saw the deceased alive on 8/12/1980, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (s) (h) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Sanford N. Richman, M.D.			DEGREE			22c. DATE SIGNED 8/13/80.							
22d. PHYSICIAN'S NAME [TYPE OR PRINT] Sanford N. Richman, M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug 16, 1980			23c. NAME OF CEMETERY OR CEMETORY Holy Trinity Episcopal			23d. LOCATION CITY OR TOWN Collington County STATE Georges Md				
24. FUNERAL DIRECTOR NAME F. Gasch's Sons P A Hyattsville, Md.						25a. DATE REC'D. BY REGISTRAR AUG 18 1980			25b. REGISTRAR'S SIGNATURE John J. Murphy				

1993-3-24

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 0 2 1 3 3 2			
										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	20. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR			
Bernard Robert Thomas						August 28, 1980				9:03A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		R		2 23 83			77						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8		9. BALTIMORE CITY OR COUNTY OF DEATH						
S. Carolina		U.S.A.			MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Montgomery						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Olney		Montgomery General Hospital								Farmer		Farming	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS			
Maryland		Howard		Daisy						2375 Duvall Road			
14. FATHER'S NAME FIRST		MIDDLE		LAST	15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST		
Richard				Thomas	Clara						Drake		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
No		218 12 8632		Alice Rebecca Thomas						Item 13			
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: <u>unknown</u> IMMEDIATE CAUSE (a) <u>unknown</u> 1509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b) <u>Sp resection esophagel ca</u> - 3 months (c) <u></u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) renal failure													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>August 27, 1980</u> to <u>August 28, 1980</u> , that (I) (we) last saw the deceased alive on <u>August 27, 1980</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Edward P. Tavbman</u>		DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/28/80</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Edward P. Tavbman</u>		22e. ADDRESS <u>1811 Prince Philip Dr. Olney Md.</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY	STATE			
Burial		Sept. 1, 1980		Daisy Church Cem.			Daisy Howard						
24. FUNERAL DIRECTOR NAME <u>Olin L. Molesworth, P.A. Damascus, Md.</u>		ADDRESS			25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE						
					SEP 2 1980								

政治小説の変遷 3

July 1, 1990, Grey Gull, First, longing

000-926 Be informed A.9 divisional air

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 21333	REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)			FIRST ELLEN	MIDDLE K.	LAST THOMAS	2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR 6:25 AM											
3. SEX Female			4. RACE Cauc.		5. DATE OF BIRTH MONTH DAY YEAR January 16 1906			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN											
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash D.C.			7b. CITIZEN OF WHAT COUNTRY? USA		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired			12b. KIND OF BUSINESS OR INDUSTRY & Telephone			
13a. STATE Md.			13b. COUNTY Pr. Geo.		13c. CITY OR TOWN Upper Marlboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 10907 Bennington Dr.											
14. FATHER'S NAME FIRST Allen			MIDDLE J.	LAST Johnson	15. MOTHER'S MAIDEN NAME FIRST Florence			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b. SOCIAL SECURITY NO none			17. INFORMANT ADDRESS Katherine Sweeney 11897 92nd way North			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 2030 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TXR		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																						
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE							
22a. I certify that (1) (this hospital) attended the deceased from <u>JULY 19 79</u> to <u>August 20, 1980</u> , that (2) (we) last saw the deceased alive on <u>Aug 19 1980</u> , and that in (3) (our) opinion death occurred on the date and hour and from the causes stated above, (4) (we) (did) (did not) view the body after death.																						
22b. SIGNATURE <u>Jones A. Brown MD</u> DEGREE															22c. DATE SIGNED 8/20/80							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Jones A. Brown MD</u>			22e. ADDRESS 6528 Belvoir Rd Kagglewick Rd 20782			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/23/80			23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery			23d. LOCATION CITY OR TOWN Suitland			COUNTY			STATE Md.							
24. FUNERAL DIRECTOR NAME Kalas 6160 Oxon Hill Rd. Oxon Hill, Md.															25a. DATE REC'D. BY REG. OFFICE AUG 25 1980			25b. REGISTRATION NO.				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)						2. DATE OF DEATH		MONTH	DAY	YEAR	21. HOUR		
		HELEN VICTORIA THOMAS						AUGUST 13, 1980		80	13	80	4:00 AM		
		3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDUE 1 YEAR		8. UNDUE 24 HRS			
		FEMALE		BLACK		MONTH DAY YEAR		78		MONTHS DAYS		HOURS MIN			
		7b. BIRTHPLACE (COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
		10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
		TAKOMA PARK, MD		WASHINGTON ADVENTIST HOSPITAL		Washington Adventist Hospital		HOUSEWIFE		PVT					
		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS					
		D.C.		WASHINGTON		WASHINGTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		914 VARNEY ST. S.E. #23					
		14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
		WILLIAM HAGER						SARAH UNK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
NO		578307998A		CATHERINE THOMAS		DAUGHTER 1000 C ST. N.E.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)															
5789 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)												EXASPERATION			
DUE TO, OR AS A CONSEQUENCE OF (b) GASTRO-INTESTINAL HEMORRHAGE															
DUE TO, OR AS A CONSEQUENCE OF (c) UNDETERMINED ETIOLOGY															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) RECURRENT BRAINER TUMOR															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1980 to 1980, that (I) (we) last saw the deceased alive on 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE Helen W. Hager		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/3/80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helen W. Hager		22e. ADDRESS 111 Spring Street Baltimore, MD 20910		23d. LOCATION CITY OR TOWN LANDOVER, MD											
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE AUG 19, 1980		23c. NAME OF CEMETERY OR CREMATORIAL HARMONY MEMORIAL		23d. LOCATION CITY OR TOWN LANDOVER, MD									
24. FUNERAL DIRECTOR NAME ALEX S. POPE		ADDRESS 2617 PENNSYLVANIA AVE. S.E.		25a. DATE REC'D. BY REGISTRAR AUG 21, 1980		25b. REGISTRAR'S SIGNATURE Helen W. Hager									

HA 001

001

T 15J

34301

11/11/14

11/11/14

11/11/14

001

T 15J

34301

11/11/14

11/11/14

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021335	REG. NO.			
1 - STATE REGISTRAR			1. DECEASED NAME [TYPE OR PRINT]			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR		
			Helen N. Thompson						August 4, 1980			4:00am		
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			# UNDER 1 YEAR		
Female			Caucasian			June 17, 1898			82			MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Pennsylvania			U.S.A.						Montgomery County					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Bethesda			4400 East West Highway			Homemaker			Home					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Montgomery			Bethesda						4400 East West Highway		
14 FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			17. SOCIAL SECURITY NO			18. INFORMANT		
Frederick Newberry			Margaret Sweeney			(If Yes, Give War or Dates) 167-10-4260			19. ADDRESS			Bridgeport, NY		
20. DECEASED FROM 7a. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)			21. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			22. DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause last			23. DUE TO, OR AS A CONSEQUENCE OF (b)					
1579						24. DUE TO, OR AS A CONSEQUENCE OF (c)								
25. MEDICAL CERTIFICATION			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
26a. DATE OF OPERATION			26b. CONDITION FOR WHICH OPERATION WAS PERFORMED			26c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			26d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
28. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			29a. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			29b. LOCATION STREET CITY OR TOWN COUNTY STATE								
30. I certify that (I) (this hospital) attended the deceased from August 1, 1979, to August 4, 1980, that (I) (we) last saw the deceased alive on August 2, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.														
31. SIGNATURE Lorraine D. Bohan			32. DEGREE			33. ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			34. DATE SIGNED 8-4-80					
35. PHYSICIAN'S NAME (TYPE OR PRINT) L.D. BOHAN			36. ADDRESS NAT NAV. MED CENTER BETHESDA											
37a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			37b. DATE 8/5/80			37c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crem.			37d. LOCATION CITY OR TOWN Alexandria, Virginia			37e. COUNTY STATE		
38. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland						39. DATE REC'D. BY REGISTRAR AUG 9 1980			40. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, an other traumatic event, the medical examiner must be notified at once.

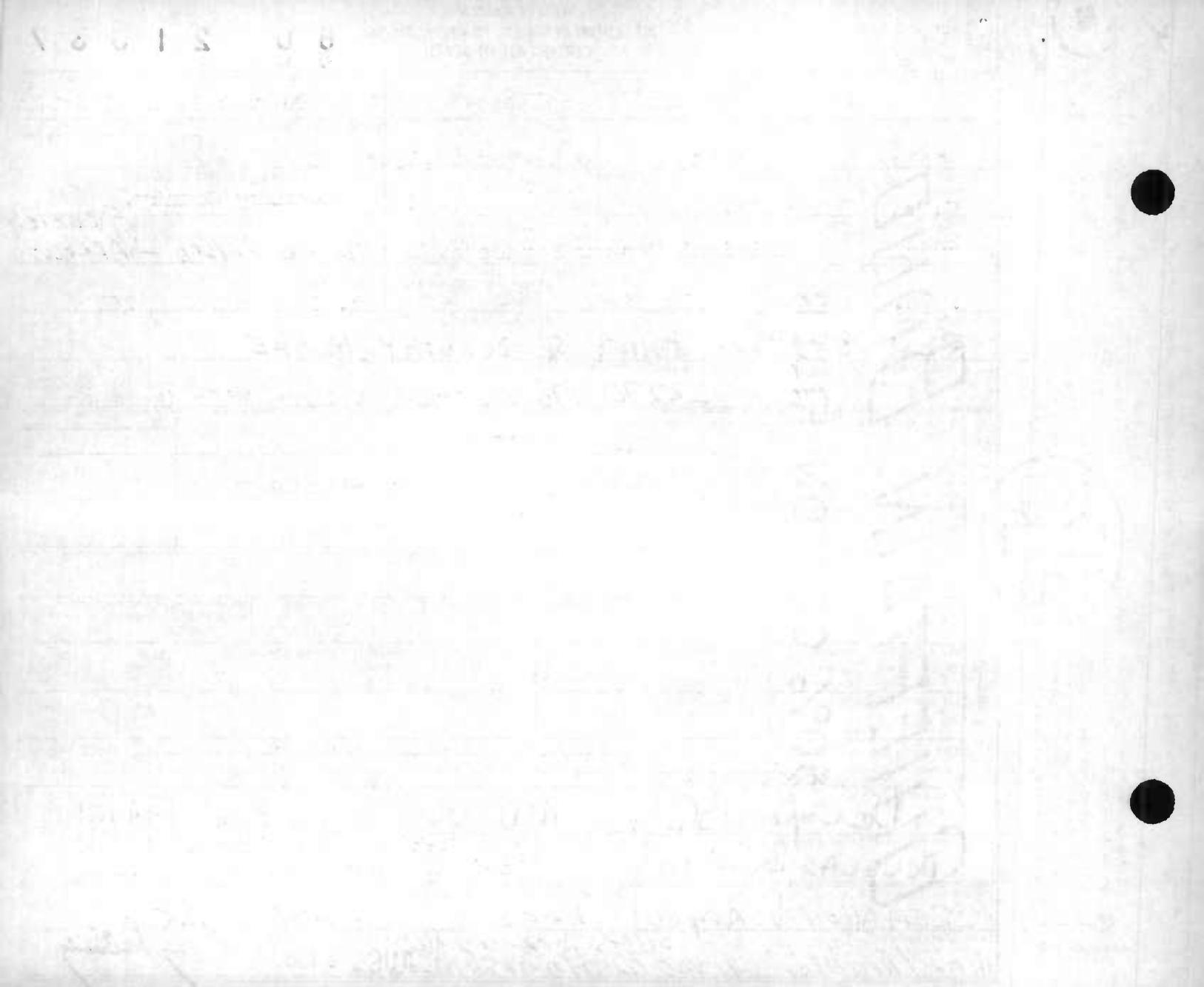
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021336	REG. NO.					
1. FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
JEANNE LOUISE TOBIN									August 8, 1980			4:30A M				
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
						January 16, 1959			21 YRS.							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD							
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Clinical Center, Bethesda, MD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student			12b. KIND OF BUSINESS OR INDUSTRY College							
13a. STATE New York			13b. COUNTY Nassau			13c. CITY OR TOWN Port Washington			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 17 Evelyn Rd 11050				
14. FATHER'S NAME FIRST MIDDLE LAST Thomas			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Patricia Martin													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 098-58-4648			17. INFORMANT Mr. Thomas F. Tobin-Father (same as above)										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Septicemia</u> <u>3849</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aplastic Anemia</u> { DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE										
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>May 28, 1980</u> to <u>August 8, 1980</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>August 8, 1980</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (XXX) view the body after death.																
22b. SIGNATURE <u>P. Pinkston M.D.</u> DEGREE										22c. DATE SIGNED <u>8/8/80</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>P. Pinkston M.D.</u>										22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, MD 20205						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 8/11/80			23c. NAME OF CEMETERY OR CREMATORIAL Holy Rood Cemetery			23d. LOCATION CITY OR TOWN Westbury, New York			STATE				
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland									25a. DATE REC'D. BY REGISTRAR AUG 8 1980			25b. REGISTRAR'S SIGNATURE <u>Robert A. Pumphrey</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80	21	337				
												REG. NO.						
1. FOR STATE REGISTRAR			I. DECEASED NAME FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			Ray			Baxton			Tolley			August 9, 1980					5:00 AM	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
Male			White			MONTH DAY YEAR			35			MONTHS DAYS		HOURS MIN.				
7b. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
W. Va.			USA			September 29, 1944			Montgomery County,									
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS INDUSTRY									
Bethesda			NIH Clinical Center, Bethesda, Md			13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13b. CITY OR TOWN			13c. STREET ADDRESS						
W. Va.			Bland			Bluefield			Rt. 2, Box 743			24701						
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT						
RAY BAXTON			DOROTHY MOORE			NO			232 705176			Mrs. Brenda Tolley, Wife (same as above)						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)						19. DUE TO, OR AS A CONSEQUENCE OF (b) DISSEMINATED METASTATIC MALIGNANT						20. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
1729 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last						DUE TO, OR AS A CONSEQUENCE OF (c) MELANOMA												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
21a. DATE OF OPERATION			21b. CONDITION FOR WHICH OPERATION WAS PERFORMED			21c. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE						
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from June 28, 1980, to August 9, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 9, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input checked="" type="checkbox"/> view the body after death.																		
22b. SIGNATURE Douglas Blayney MD			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 9 Aug 80									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Douglas Blayney			22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, Md. 20205															
23a. BURIAL, CREMATION, REMOVAL CREMATION			23b. DATE 10 Aug 80			23c. NAME OF CEMETERY OR CREMATORIAL Lees			23d. LOCATION CITY OR TOWN WASH.			23e. COUNTY STATE D.C.						
24. FUNERAL DIRECTOR NAME Hines Ronald			24b. ADDRESS 11800 New Hampshire			24c. DATE REC'D. BY REGISTRAR AUG 14 1980			24d. REGISTRAR'S SIGNATURE Henry McCreary									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021338			
										REG. NO.			
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR			
I. DECEASED NAME (TYPE OR PRINT)			LAST			8-3-80		255PM					
Alice M. Tomlin													
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		
Female		Caucasian		Sept. 20, 1889			90 YRS.						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD				
England		U.S.A.					Montgomery County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Bethesda		Bethesda Health Center					Practical Nurse Hospital						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		3312 Chiswick Court		
Maryland		Montgomery		Silver Spg.									
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Alfred Moseley			Elizabeth							Cooper			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS				
No			069-24-7009			A Carl F. Tomlin, Same as #13							
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
481- cardiovascular collapse DUE TO, OR AS A CONSEQUENCE OF Lobar Pneumonia										commenced 6 days			
Conditions, if any, which gave rise to immediate cause 1a, stating the underlying cause, if any													
(b) DUE TO, OR AS A CONSEQUENCE OF Lobar Pneumonia													
(c)													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)													
generalized arteriosclerosis													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
				<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART II)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Feb. 3, 1977, to August 3, 1980, that (I) (we) last saw the deceased alive on Aug. 30, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Waldred R. Ettermantrout MD										DEGREE			
22c. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22d. DATE SIGNED 8/3/80			
22e. ADDRESS 1125 Rockville Pike, Rockville Md			201852										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 8/4/80		23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crem.			23d. LOCATION CITY OR TOWN Alexandria		COUNTY		STATE Virginia		
Cremation													
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Bethesda, Maryland		25b. DATE REC'D. BY REGISTRAR AUG 8 1980		25c. REGISTRAR'S SIGNATURE Victory McAdoo									

16
1. FOR
- STATE
REGISTRAR
EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR.
PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3, RETAIN PAGES 1, 2, AND 3 FOR YOUR FILES.
AFTER DEATH, WITH THE STATE, DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET,
BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH
REG. NO. 8021339

1. DECEASED NAME (TYPE OR PRINT)	FIRST MIDDLE LAST			2a. DATE KNOWN OF DEATH ESTIMATED	MONTH	DAY	YEAR	2b. HOUR M				
John J. Toomey				<input checked="" type="checkbox"/>	8	28	1980	80				
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN			7c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR PM
male	white	Oct 25, 1919	60 yrs.					8	28	1980	12:48	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED	X NEVER MARRIED			9. BALTIMORE CITY OR COUNTY OF DEATH				
WASHINGTON, D. C.	U.S.A.			<input checked="" type="checkbox"/>	<input type="checkbox"/>			Montgomery County MD.				
CITY OR TOWN OF DEATH Bethesda				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY
				Suburban Hospital				ATTORNEY				
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS						
MARYLAND	MONTGOMERY	KENSINGTON			<input checked="" type="checkbox"/>	4215 DUNNEL LANE						
14. FATHER'S NAME FIRST MIDDLE LAST	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
VINCENT L. TOOMEY	CATHERINE McCANN											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)	16b. SOCIAL SECURITY NO.			17. INFORMANT	ADDRESS							
YES WW II	579-18-4533			BETTY S. TOOMEY	SAME AS 13			WIFE				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF 4292 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from <input checked="" type="checkbox"/> Natural causes, <input type="checkbox"/> Accident, <input type="checkbox"/> Suicide, <input type="checkbox"/> Homicide, <input type="checkbox"/> Undetermined manner												Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion
ACTUAL SIGNATURE <i>J. Guard</i>												TITLE (SPECIFY) Assistant M.D. MEDICAL EXAMINER
EXAMINER'S NAME Hormez R. Guard, M.D. ADDRESS 111 Penn Street, Balto., MD 21201												DATE SIGNED 8/28/80
23a. BURIAL, CREMATION, REMOVAL 1. SPECIFY	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		COUNTY		STATE			
BURIAL	8/30/80	GATE OF HEAVEN			SILVER SPRING		MONT		MD.			
24. FUNERAL DIRECTOR NAME <i>Francis J. Collins</i>	24b. ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE <i>harry k. alredy</i>				
				SEP 2 1980								

M

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked as "No" show any injury, or other traumatic event, the medical examiner may be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8021340
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			21. HOUR			
Francis			Lucian Tuck			8/8/80			7:35AM			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
Male		White		Sept. 14 1899			80 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Washington D.C.		U.S.A.					Montgomery County					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Bethesda		Suburban Hospital					Certified Pub, Acc			Self Empol/		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Maryland		13b. COUNTY Montgomery		13c. CITY OR TOWN Potomac			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 9400 River Road		
14. FATHER'S NAME FIRST Frank		MIDDLE —		LAST Tuck			15. MOTHER'S MAIDEN NAME FIRST Sally			MIDDLE —		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Wife			18. ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		577 56 3272		Maybelle G. Tuck			Same as #13			IMMED.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) VENTRICULAR FIBRILLATION												
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost (b) ARTERIOSCLEROTIC HEART DISEASE DUE TO, OR AS A CONSEQUENCE OF (c) YEARS												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CHRONIC RENAL INSUFFICIENCY												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>1978</u> to <u>1980</u> , that (I) (we) last saw the deceased alive on <u>JULY 1980</u> , and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (I did not view the body after death)												
22b. SIGNATURE <i>Stephen J. Williams</i>		22c. DEGREE MD		22d. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 5/8/80					
22f. PHYSICIAN'S NAME (TYPE OR PRINT) STEPHEN J. WILLIAMS, MD		22g. ADDRESS 1712 EYE ST. NW. WASHINGTON, D.C.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE Aug. 11, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Ft. Lincoln Cemetery			23d. LOCATION CITY OR TOWN Brentwood, Prince Geo.			COUNTY STATE Md.		
24. FUNERAL DIRECTOR NAME Robert A. DeVol		ADDRESS 2222 Wisc Ave Washington D.C.		25a. DATE REC'D. BY REGISTRAR AUG 15 1980			25b. REGISTRAR'S SIGNATURE					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be sent to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 21341				
REG. NO.																
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
MARION			A.						TURNERY			AUG	23	80		6:25A
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS				
FEMALE		WHITE		JULY 21, 1908			72			MONTHS	DAYS	HOURS	MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.						
NEW YORK		U.S.A.					MONTGOMERY									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
SILVER SPRING		9523 BRUCE DRIVE		BURSAR			MONTGOMERY COLLEGE									
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 9523 BRUCE DRIVE						
14. FATHER'S NAME FIRST WILLIAM		MIDDLE H.		LAST MORSE			15. MOTHER'S MAIDEN NAME FIRST JESSIE			MIDDLE		LAST HINDS				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR DATES) 217-28-8516		17. INFORMANT SON EDGAR W. TURNERY			ADDRESS 1611 SANFORD ROAD SILVER SPRING, MD.			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 MONTHS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>EXTENSIVE ABDOMINAL CANCER</u>																
1952 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any (b) <u>ADENOCARCINOMA</u>																
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHITE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1-17 19 80 to 8-23 19 80, that (I) (we) lost saw the deceased alive on 8-1 19 80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED Aug. 23, 1980				
22b. SIGNATURE <u>Hubert J. Alpert, M.D.</u>		22c. DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HUBERT ALPERT		22e. ADDRESS 8630 FENTON STREET, SILVER SPRING, MD.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8/26/80		23c. NAME OF CEMETERY OR CREMATORIAL CRANFORD MEMORIAL			23d. LOCATION CITY OR TOWN LORTON			COUNTY		STATE VIRGINIA				
24. FUNERAL DIRECTOR NAME FRANCIS J. COLLINS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901		25a. DATE REC'D. BY REGISTRAR AUG 26 1980			25b. REGISTRAR'S SIGNATURE <u>Patricia Kennedy</u>											

VERGITT

21740-2

STOOL EXAMINATION

UNIVERSITY OF TORONTO LIBRARIES

23-3

卷之三

0893 3 5 300

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 8021342												
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE KNOWN OF ESTI- DEATH MATED			2b. MONTH DAY YEAR 8/1/80 9 AM									
Eleanora						Upatnieks						<input checked="" type="checkbox"/>												
3. SEX		4. RACE		5. DATE OF BIRTH MO. DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. MONTH DAY YEAR Aug 1 1980 9 AM									
Female		Cauc.		Oct. 28 1893		86 yrs.						<input checked="" type="checkbox"/>												
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH																
Latvia		Latvia		<input checked="" type="checkbox"/>		<input type="checkbox"/>		Montgomery																
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY																	
Bethesda		Suburban Hospital		Social Worker			Counseling																	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13a. STATE Maryland			13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda,		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS #3 Pooks Hill Road Apr. 902		
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST												
Peter				Jegers		Karlina						Jegers												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT			ADDRESS																	
No		386-52-2461		Mirdza Lelis (See Item # 13)																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cardioVascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. 4292																								
(b) <u>Chronic Congestive Heart Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c)																								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?																		
						<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE																		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																								
ACTUAL SIGNATURE		John G. Ball										TITLE (SPECIFY) M.D. <i>DeLoach</i>		MEDICAL EXAMINER Bethesda, Md.										
EXAMINER'S NAME (TYPE OR PRINT)		John G. Ball										ADDRESS 7936 Old Georgetown Rd.		DATE SIGNED Aug. 6, 1980										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Aug. 6, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Metropolitan Crem.			23d. LOCATION CITY OR TOWN Alexandria			CITY COUNTY STATE Virginia												
Cremation																								
24. FUNERAL DIRECTOR NAME Robert A. Bumphrey Funeral Homes, P.A. Bethesda, Md.						25a. DATE REC'D. BY REGISTRAR AUG 8 1980			25b. REGISTRAR'S SIGNATURE <i>John G. Ball</i>															

GRAN

granos

granos

granos

granos

granos

granos

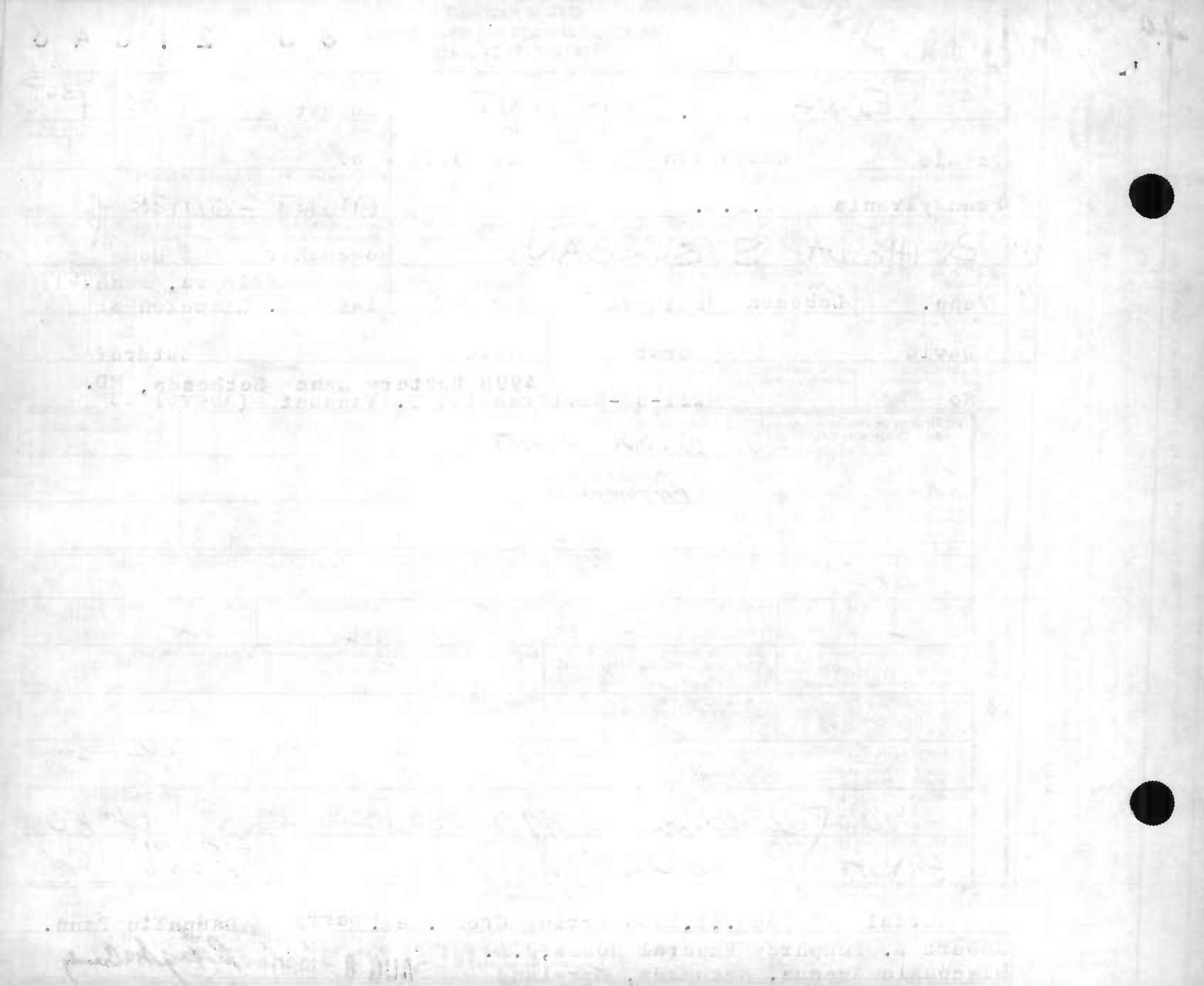
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 21343					
1 - STATE REGISTRAR				I. DECEASED NAME (TYPE OR PRINT)				EDNA H. VANSANT				2a. DATE OF DEATH MONTH DAY YEAR		7 80		2b. HOUR 4:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR				May 11 1911				6. AGE (IN YEARS LAST BIRTHDAY)		69 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female		Caucasian		MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>								9. BALTIMORE CITY OR COUNTY OF DEATH		MONTGOMERY MD.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				BETHESDA SUBURBAN				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
Pennsylvania		U.S.A.															
10. CITY OR TOWN OF DEATH		13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		Palmyra, Penn.	
BETHESDA						Penn.		Lebanon		Palmyra						149A N. Lincoln St	
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST				LAST							
David				Horst		Annie										Baldrof	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS				4998 Battery Lane Bethesda, MD.									
No		221-30-8271		Franklin D. Vansant (Above) #13													
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIAC ARREST																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
> 486- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b). (b) PREMATURE																	
DUE TO, OR AS A CONSEQUENCE OF (c) PREMATURE																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) AGE																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
19c. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (1) this hospital attended the deceased from saw the deceased alive on above, (1) (we) did not view the body after death.		22b. SIGNATURE Eduard Goustein MD		22c. DEGREE MD		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22d. DATE SIGNED 8/19/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eduard R Goustein		22e. ADDRESS 3410 6th Street, Georgetown, MD															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Aug. 11, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Spring Creek Cem. Derry		23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE							
24. FUNERAL DIRECTOR Robert A. Pumphrey Funeral Homes, P.A. Wisconsin Avenue, Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 8 1980		25b. REC'D. BY CLERK'S SIGNATURE Pumphrey Holmberg													

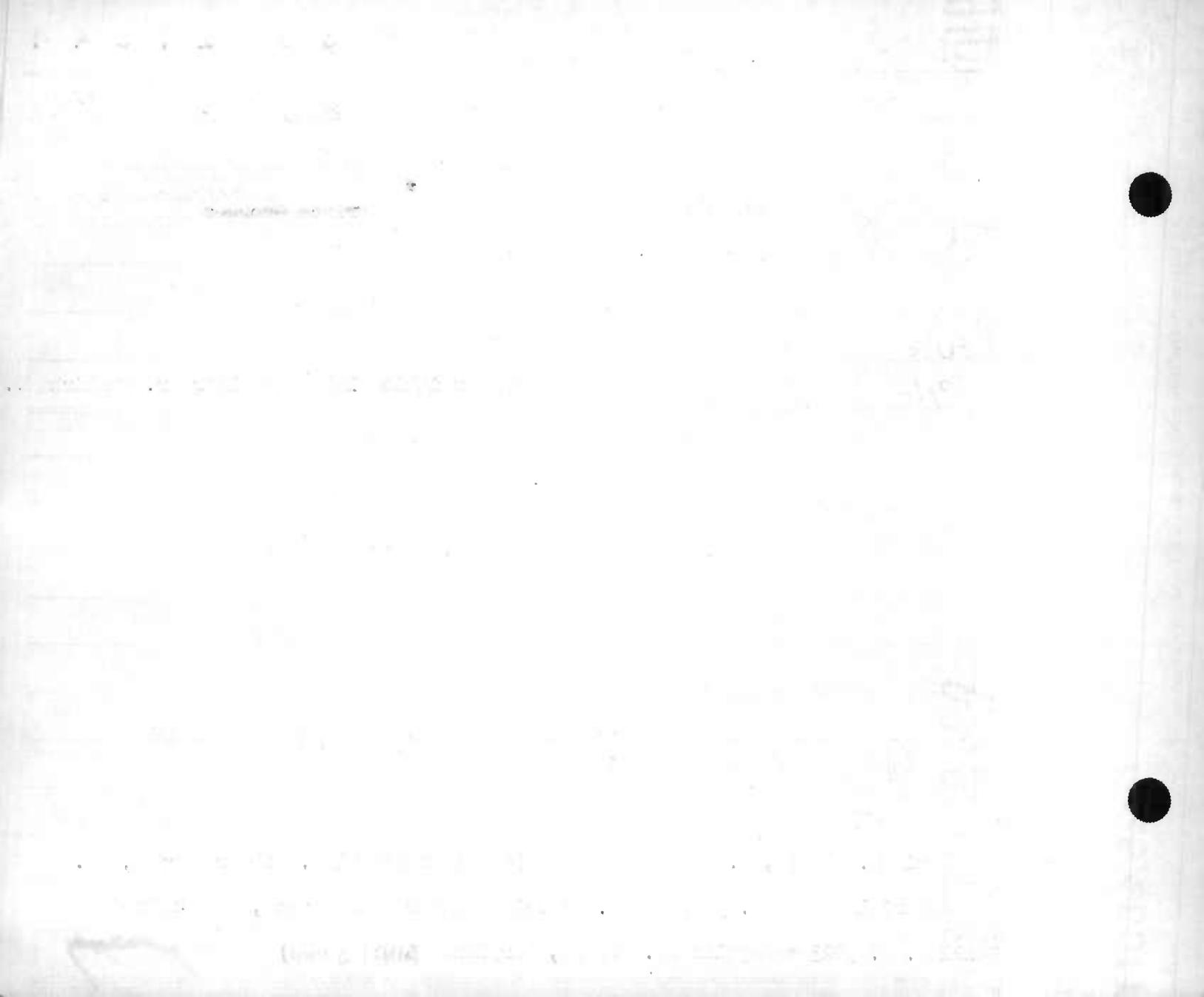


TO HOSPITAL OR ATTENDING PHYSICIAN The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician

TO FUNERAL DIRECTOR After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 80 21344			
1. DECEASED NAME (TYPE OR PRINT)			Ronald Keith Vermillion			2. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Ronald Keith Vermillion						8/6/80			8/6/80	2:30 P.M.					
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		2 2 60			20			MONTHS	YEARS	HOURS	MIN		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. DATE OF BIRTH			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH					
Wash. D.C.		A. U. S. A.		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			MONTGOMERY			Takoma Park					
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Washington Adventist				Student											
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13b. STREET ADDRESS			
13a. STATE Md.		13b. COUNTY P. G.		13c. CITY OR TOWN Hillside			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1931 Brooks Drive					
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
Lewis W. Vermillion			Ruth Vermillion			No			218-84-2661			Ruth Vermillion 12164 Cavalier Dr. Dunkirk Md.			
18. CAUSE OF DEATH (Enter only one cause per line for 18, 19, and 20.) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (1o)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
2028 Conditions, if any, which gave rise to immediate cause (1o), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (b) <i>cardiovascular disease</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>generalized lymphoma</i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/16/80 to 8/6/80, that (I) (we) last saw the deceased alive on 7/16/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.									8/6/80		8/6/80				
22b. SIGNATURE <i>Lewis H. Dennis, Md.</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>8/6/80</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lewis H. Dennis, Md.			22e. ADDRESS 831 University Blvd. Silver Spring, Md.												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Aug. 9 1980			23c. NAME OF CEMETERY OR CREMATORIUM Mt. Lincoln Cemetery			23d. LOCATION Brentwood, Maryland			23e. STATE			
24. FUNERAL DIRECTOR Beall F. H. 9013 Annapolis Rd. Lanham, Maryland			25a. DATE REC'D. BY REGISTRAR AUG 15 1980			25b. REGISTRATION NO.									





FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 30

21345

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A AIRMAIL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR RECREMATION.

1. DECEASED NAME (TYPE OR PRINT)		FIRST FRANK	MIDDLE HENRY	LAST VOGEL, JR.	2a. DATE KNOWN OF DEATH ESTIMATED MATED	□ MONTH M 8	DAY 31	YEAR 1980	2b. HOUR M 1 A M
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Dec. 22, 1917	6. AGE (IN YEARS LAST BIRTHDAY) 62 yrs.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH 8	DAY 31	YEAR 1980
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ohio		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED X NEVER MARRIED WIDOWED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			2d. HOUR M 8 A M
10. CITY OR TOWN OF DEATH Rockville		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 11708 Magruder Lane			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Col.		12b. KIND OF BUSINESS OR INDUSTRY U.S. Marine		
13a. STATE Md.	13b. COUNTY Montg.	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES X NO		13e. STREET ADDRESS 11708 Magruder Lane				
14. FATHER'S NAME FIRST Frank H. Vogel, Sr.		MIDDLE LAST	15. MOTHER'S MAIDEN NAME Alice		16. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ACUTE				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. WW II		16c. INFORMANT Ann B. Vogel		17. ADDRESS Same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: 410- IMMEDIATE CAUSE (a) <u>CORONARY THROMBOSIS</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>CORONARY ARTERIOSCLEROSIS</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c) _____									
19. PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). 19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? 19c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8 P.M. 8 31 1980		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Found on floor of bathroom					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET 11708 Magruder Lane CITY OR TOWN Rockville COUNTY Md. STATE					
22a. I certify that I took charge of the remains described above, held on <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE TITLE (SPECIFY) Francis C. Mayle, M.D. Deputy MEDICAL EXAMINER EXAMINER'S NAME (TYPE OR PRINT) Francis C. Mayle, M.D., ADDRESS 8200 Wisconsin Ave. 1205 BP									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 3, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l.		23d. LOCATION CITY OR TOWN Arlington, Va. COUNTY STATE			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A.		ADDRESS Bethesda, Md.		25a. DATE REC'D. BY REGISTRAR (25b. REGISTRATION NO.) SEP 8 1980 					
1205 BP DHMH-17 FVR A15 ME (5) 15M 7/76									

0801 3936

TO HOSPITALS ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 21346			
REG. NO.															
1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			
Frank			Milton						VOLK			August 17, 1980			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR						
Male		White		Feb. 5, 1895			85		9:15 AM						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7d. BALTIMORE CITY OR COUNTY OF DEATH								
Maryland		USA					Montgomery County								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Damascus		27712 Ridge Road										Clergyman		MD.	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
13a. STATE Maryland		13b. COUNTY Montg.		13c. CITY OR TOWN Damascus			27712 Ridge Road								
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST			
John					Volk			Clara				Della			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		215 36 2085		Viola W. Volk, Item 13				PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Portal Hypertension</i>		2-3 mths					
1991		DUE TO, OR AS A CONSEQUENCE OF (b) <i>metastatic Ca to Liver</i>								2-3 yrs					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7-11-80</i> to <i>8-17-80</i> , that (I) (we) last saw the deceased alive on <i>7-11-80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.												22c. DATE SIGNED <i>8-18-80</i>			
22b. SIGNATURE <i>Thomas P. Sloan MD</i>		22c. DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas P. Sloan		22e. ADDRESS 9701 Church St., Damascus, Md. 20750													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 20, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Montgomery Meth.		23d. LOCATION CITY OR TOWN Damascus, Montgomery, Md.		COUNTY		STATE					
24. FUNERAL DIRECTOR Olin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR AUG 21 1980		25b. REC'D. BY							

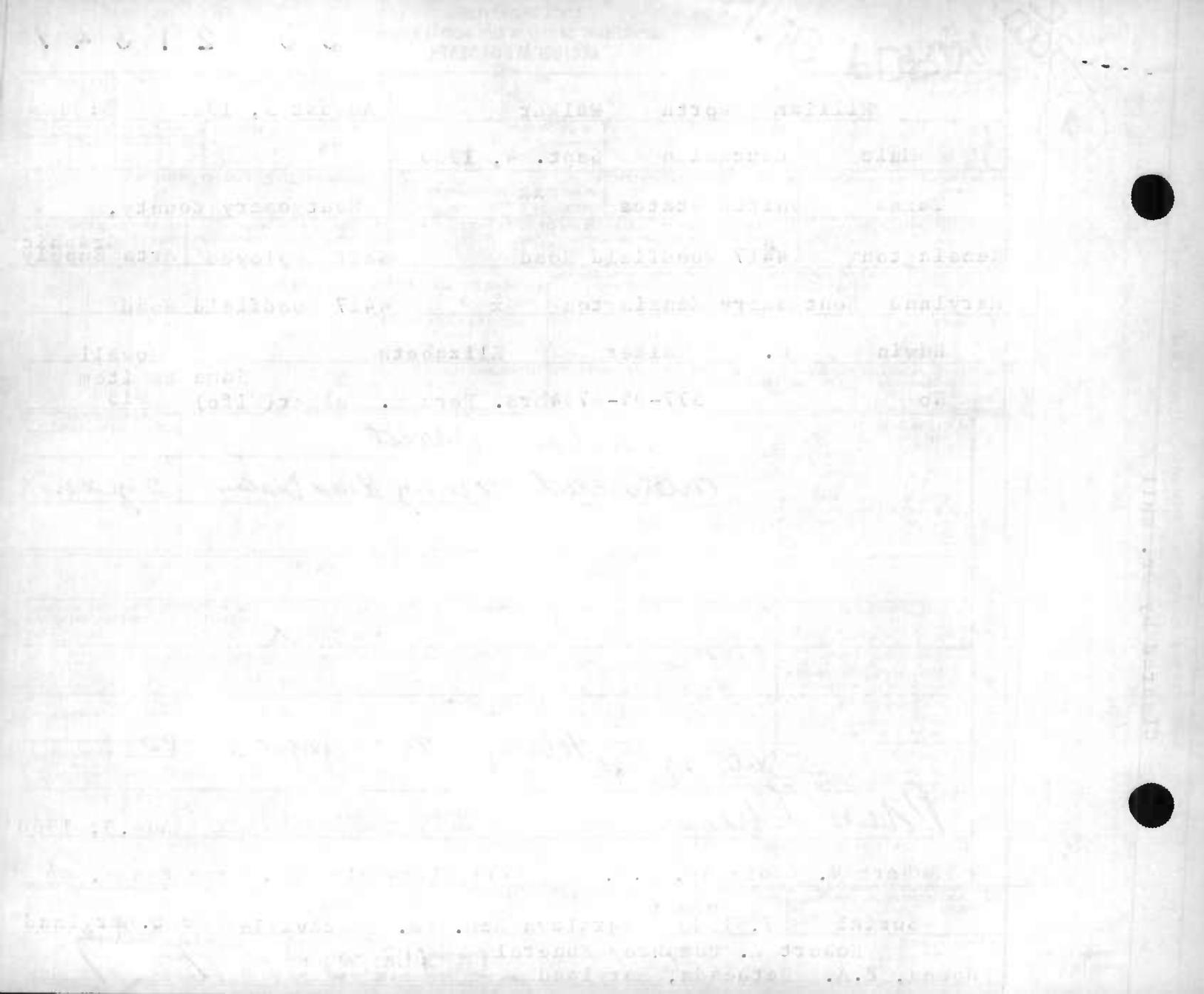
Cleared by Dr. Ball

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 21347
1. DECEASED NAME FIRST MIDDLE LAST										REG. NO.
William Worth Walker										August 5, 1980
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR			2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR			
Male	Caucasian	Sept. 4, 1900			6 AGE (IN YEARS LAST BIRTHDAY)	79	5:00 A.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		7d. BALTIMORE CITY OR COUNTY OF DEATH			
Texas		United States					Montgomery County, MD.			
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Kensington		4417 Woodfield Road			Self Employed		Graphic Arts Supply			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Maryland		Montgomery		Kensington				4417 Woodfield Road		
14 FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Edwin H. Walker		Elizabeth								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No		577-05-6794		Mrs. Fern S. Walker (Wife)		Same as item #13				
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>										
4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Arteriosclerotic coronary heart disease</i> 2 years (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a:										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>February 25</i> , 1980, to <i>Aug. 5</i> , 1980, that (I) (we) last saw the deceased alive on <i>July 29</i> , 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert V. Choisser.</i>		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Aug. 5, 1980				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS								
Robert V. Choisser, M.D.		5530 Wisconsin Ave. Chevy Chase, MD								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 7, 1980		23c. NAME OF CEMETERY OR CREMATORIUM Parklawn Mem. Pk.		23d. LOCATION CITY OR TOWN Rockville		COUNTY STATE Montgomery, Maryland		
24 FUNERAL DIRECTOR NAME		Robert A. Pumphrey Funeral Homes, P.A.		25a. DATE REC'D. BY REGISTRAR AUG 8 1980		25b. DATE ISSUED 1980				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be referred to by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 18 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8021348	
											REG. NO.		
1 - STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
	ALFRED					WALLNER	8 - 29 - 80				1252 PM		
3 SEX	4 RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
Male	White			February 10, 1906			74						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH				
Poland			U. S. A.						Montgomery				
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			MD.	
Takoma Park			Washington Adventist Hospital			Barber			Barbering				
13a. STATE Maryland			13b. COUNTY Montgomery			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 6111 Mantrase Road, #822				
14. FATHER'S NAME FIRST Israel			MIDDLE LAST Wallner			15. MOTHER'S MAIDEN NAME FIRST Adele			MIDDLE LAST Weiss				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Bernhard Schwarz			9903 East Light Drive Silver Spring, Maryland			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			579-40-5547										
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Asystole</u>													
7101 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last b) <u>lung, cardiac, CNS & renal disease</u>													
DUE TO, OR AS A CONSEQUENCE OF b) <u>lung, cardiac, CNS & renal disease</u>													
DUE TO, OR AS A CONSEQUENCE OF c) <u>Progressive Systatic Ellrosis</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <u>Sephaemur</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that (s) this hospital attended the deceased from saw the deceased about <u>8/29/80</u> to <u>8/29/80</u> , above, (if we did not) view the body after death						7101 19 80 to 8/29 80			and that in (my) (our) opinion death occurred on the date and hour and from the causes stated				
22b. SIGNATURE <u>Suburb SB Bach</u>						DEGREE <u>MD</u>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>8/29/80</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>HERBERT SARAF, MD</u>			22e. ADDRESS <u>8750 GEORGIA AVE SILVER SPRINGS</u>										
23a. BURIAL, CREMATION, REMOVAL <u>Burial</u>			23b. DATE <u>8/31/1980</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>King David Memorial Garden Falls Church, Virginia</u>			23d. LOCATION CITY OR TOWN			COUNTY	STATE
24. FUNERAL DIRECTOR NAME <u>Donald M. Stein Hebrew Memorial F.H.</u>			ADDRESS <u>232 Carroll Street, N. W. Washington, D. C.</u>			25a. FILED BY <u>SEP 3 1980</u>			25b. REGISTERED BY <u>ms</u>				

12978

0009 6408

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or if Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021349				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
BELLE J. WEISS									8	14	80		12:30 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female		White		July 17, 1906			74			MONTHS	YEARS	MONTHS	HOURS	MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.			
New York		USA						Montgomery						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Rockville		Potomac Valley Nursing Home			Manager (Ret)			Hotel						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Maryland		Montgomery		Sil Spg.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1220 East West Highway						
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO			17. INFORMANT ADDRESS				
		(nnm) MAX (nnm) COHEN		SOPHIE (nnm)			071-18-8685			Myrna Fivel, 710 A St., SE., Wash., DC				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										36 hours				
(b) <u>Cerebral thrombosis - midbrain</u>														
(c) <u>Hyperensive cardiovascular disease</u>										10+ years				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus, autoimmune disease (Sjogren's syndrome).</u>														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?						
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>8/13</u> 19 <u>80</u> , to <u>8/14</u> 19 <u>80</u> , that (II) (we) last saw the deceased alive on <u>8/13</u> 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) <input type="checkbox"/> view the body after death.)														
22b. SIGNATURE <u>Richard M. Huffman</u> DEGREE M.D.										22c. DATE SIGNED <u>8/14/80</u>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>RICHARD M. HUFFMAN, M.D.</u>										22e. ADDRESS <u>3301 NEW MEXICO AVE, N.W. WASH. D.C.</u>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Aug 17, '80			23c. NAME OF CEMETERY OR CREMATORIAL So. Fallsburg Cem.			23d. LOCATION CITY OR TOWN Glen Wild, N.Y.		COUNTY			STATE	
24. FUNERAL DIRECTOR NAME								25a. DATE REC'D. BY REGISTRAR <u>AUG 25 1980</u>		25b. REG. NO. 555				
Danzansky-Goldberg Chapels: 1170 Rockville Pike														

BP _____

W.M. & S. A. M.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 21350																							
REG. NO.																																			
1 - STATE REGISTRAR			I. DECEASED NAME			FIRST			MIDDLE			LAST			20. DATE OF DEATH			MONTH	DAY	YEAR	24 HOUR														
			CAROLYN G									WERNER			8 5 80						230 PM														
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			IF UNDER 1 YEAR		IF UNDER 24 HRS												
FEMALE			White.			MONTH 5 DAY 03 YEAR 42			38 YRS.			Richmond Virginia.			U. S. A.			Montgomery.			MONTHS		DAYS		HOURS		MIN								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			13. MOTHER'S MAIDEN NAME			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
Silver Spring			Holy Cross Hospital												John P. Gillette.			Bertha V. Hedstrom.			No.			216-38-5127			Roger Werner (Husband.) (13 e)			1749 Hepatic Metastases			6 mos.		
PART I. DEATH WAS CAUSED BY			IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			DUE TO, OR AS A CONSEQUENCE OF (c)																										
1749						Adenocarcinoma of Breast																											3 years.		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																																			
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE																				
22a. I certify that (I) (the hospital) attended the deceased from May 19 79 to Aug 5 1980, that (I) (we) last saw the deceased alive on 8/5/80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																																			
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED																							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						ADDRESS																					8/5/80								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. LOCATION CITY OR TOWN			23f. LOCATION CITY OR TOWN			23g. LOCATION CITY OR TOWN			23h. LOCATION CITY OR TOWN			23i. LOCATION CITY OR TOWN											
Cremation.			Aug. 8, 1980, Lincoln																								Bladensburg Rd. P. G. Co.								
24. FUNERAL DIRECTOR			25a. CASSIDY ST. W. D.			25b. DATE REC'D. BY REGISTRAR			25c. REGISTRAR'S SIGNATURE																										
John W. Weller			Washington D.C. 20012			AUG 0 1980																													

卷之三

Classification of Vascular Tumors

• 3 •

RECORDED BY HOSPITAL OR ATTENDING PHYSICIAN.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										80 21351					
										REG. NO.					
1 - STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR							2b. HOUR					
1 DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			August 7, 1980							4:04pm		
3 SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		Caucasian		March 13 1909			71			MONTHS DAYS		HOURS MIN			
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		U.S.A.					Montgomery County								
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Rockville		Shady Grove Adventist Hosp.					photographic Printer Ret.								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)															
13a. STATE Md.		13b. COUNTY Montg.		13c. CITY OR TOWN Rockville			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 199 Rollins Avenue					
14. FATHER'S NAME FIRST William		MIDDLE C.		LAST Craver			15. MOTHER'S MAIDEN NAME FIRST Rosa			MIDDLE Mae		LAST Lare			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT 907 Allen Rd, Rockville, Md.			18. ADDRESS 20851								
NO		579-03-0069		Virginia E. Osmond											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH about					
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any										DUE TO, OR AS A CONSEQUENCE OF (b) <i>late myocardial infarct</i>					
										DUE TO, OR AS A CONSEQUENCE OF (c) <i>arteriosclerotic heart disease</i>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										3 years					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (he) (she) attended the deceased from _____, 19____, to _____, 19____, that (I) (he) (she) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (he) (she) (did) (did not) view the body after death.										22b. SIGNATURE William H. Killay					
22c. DEGREE										22d. DATE SIGNED 8-8-80					
22e. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>															
22f. PHYSICIAN'S NAME (TYPE OR PRINT)			22g. ADDRESS 8218 Wisc. Ave., Bethesda, Md. 20014												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 19 Aug. 11, 80		23c. NAME OF CEMETERY OR CREMATORIUM Union Chapel			23d. LOCATION CITY OR TOWN Libertytown		COUNTY		STATE Md.			
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Home's P.A.			25a. DATE REC'D. BY REGISTRAR AUG 8 1980							25b. REGISTRAR'S SIGNATURE Robert A. Pumphrey					

Cleared by Dr. John Rogers, Medical Examiner

TO HOSPITAL ATTENDING PHYSICIAN

ed within 24 hours after death. Page 4 may be

DHMH-16 25M
(VRA 15, 4) 1/79

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

3 0 2 1 3 5 2

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR									
Donald K. Willett, Sr.									August 28, 1980			3:13A M									
3 SEX		4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS									
Male		WHITE		MONTH DAY YEAR			60			MONTHS DAYS		HOURS MIN									
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.											
MARYLAND		U.S.A.					Montgomery														
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY														
Silver Spring		Holy Cross Hospital		ENGINEER			F.A.A.														
13a. STATE Maryland												13b. COUNTY Montgomery		13c. CITY OR TOWN Silver Spring		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1813 Sanford Road		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																		
LOUIS G. WILLETT			MAUDE V. OWENS																		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS												
YES WW II			215-16-1415			TERESA D. WILLETT			SAME AS 13 WIFE												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>																					
410- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Probable M.I.</i>									
{ DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE									
22a. I certify that <input checked="" type="checkbox"/> (his/his) hospital attended the deceased from <i>Aug 28, 1980</i> to <i>Aug 28, 1980</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>Aug 28, 1980</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.												22c. DATE SIGNED <i>28 Aug 80</i>									
22b. SIGNATURE <i>Philip Battarovi</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>																
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS <i>Holy Cross Hospital Emergency Dept</i>																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN		23e. COUNTY		STATE										
BURIAL		8/30/80		GATE OF HEAVEN			SILVER SPRING		MONT		MD.										
24. FUNERAL DIRECTOR NAME <i>FRANCIS J. COLLINS</i> ADDRESS <i>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</i>						25a. DATE REC'D. BY REGISTRAR <i>SEP 2, 1980</i>						25b. REGISTRAR'S SIGNATURE <i>Patricia McCreedy</i>									

Torti subtriangularis

be executed within 24 hours after ~~date~~ Page 4 may be

TO HOSPITAL OR ATTENDING PHYSICIAN: The

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021353						
										REG. NO.						
1 - FOR STATE REGISTRAR																
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE			LAST			2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
Joseph	Edward						WILLIAMSON			August		2	1980	3:00P M		
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male	Caucasian			MONTH Feb. DAY 21 YEAR 1917			63			MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8			9. BALTIMORE CITY OR COUNTY OF DEATH			YRS.						
New York	USA			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Montgomery			MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Bethesda	National Naval Medical Center										U.S. Air Force		Lt. Col. (Ret.)			
13a. STATE	13b. COUNTY	13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS								
Virginia	Fairfax	Great Falls			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			929 Welham Green Road								
14. FATHER'S NAME	MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			ADDRESS						
Joseph				Williamson			Kethryn			Brady						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Yes	1937-63			117 01 5153			Joseph B. Williamson			See item 13						
1629							Carcinoma of the lung									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(b)															
	(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
Perforated duodenal ulcer																
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED										20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
											YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)												
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>June 21</u> , 19 <u>80</u> , to <u>August 2</u> , 19 <u>80</u> , that (I) (we) last saw the deceased alive on <u>August 2</u> , 19 <u>80</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE	22c. DATE SIGNED															
Robert Chin, M. D.				MD			ATTENDING PHYSICIAN <input type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input checked="" type="checkbox"/>		Aug. 4 1980			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS															
Robert Chin, M. D.	National Naval Medical Center, Bethesda, Md.															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			23e. DATE REC'D. BY REGISTRAR						
Burial	Aug 6 1980			HollyHood Cem			Brookline			Mass.						
24. FUNERAL DIRECTOR NAME	ADDRESS										25b. REGISTRAR'S SIGNATURE					
Pearson Funeral Home	Falls Church, Va.										AUG 11 1980					

6881-120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 21354	
												REG. NO.	
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			George KENNETH WOHLER						Aug 28 1980			8:51 AM	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
MALE			W			10 - 2 - 1889			91			YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Connecticut			USA						Montgomery			Dam Building	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			WAH 7000 Carroll Ave. Toma Park.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
MD									Engineer			Dam Building	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
Maryland			Montg.			Damascus						8475 Gue Road	
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST										
Peter Wohler			Mariah Field										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
NO			111-12-4593			Pat Miller			Item 13			months	
18. CAUSE OF DEATH (Enter only one cause per line for 18a, b, and c.) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>benign prostatic hyperplasia</i>													
DUE TO, OR AS A CONSEQUENCE OF (b) <i>adenocarcinoma of the rectum with</i>													
DUE TO, OR AS A CONSEQUENCE OF (c) <i>liver metastasis -</i>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (the hospital) attended the deceased from 8/25/80 to 8/28/80, that (I) (we) last saw the deceased alive on 8/27/80 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) (did not) view the body after death.													
22b. SIGNATURE <i>Dr. F. W. B. Molesworth</i>			DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 8/28/80				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>F. W. B. Molesworth</i>			22e. ADDRESS <i>83 University Blvd E Silver Spring, Md.</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept 1, 1980			23c. NAME OF CEMETERY OR CREMATORIAL Newport Ceme.			23d. LOCATION CITY OR TOWN Newport			COUNTY STATE New York	
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A. Damascus, Md.			ADDRESS			25a. DEATH CERTIFIED BY REG. DIRECTOR SEP 2 1980			25b. REG. DIRECTOR <i>Dr. F. W. B. Molesworth</i>				

8:21 A

1980-8-21

993-300

John P. Hoffmeyer, P.A. Damascus, Md.

Burnett Sept 1, 1980 Newport Ctr., New York

X

leaving

no
Perfor
Mopier
Matsup
Mopier
8475 Gage Road
Majlis
Damascus
Mopier
X
8475 Gage Road
Damascus
Mopier
Matsup
Mopier
III-15-4233 Date Mopier
Item 13

Count age USA

Montgomery

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 0 2 1 3 5 5	
											REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
DAUNE			MARIE	WOLFE		August 6, 1980						11:50P _M	
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
Female			White			Month Day Year May 10, 1949			31			IF UNDER 24 HRS MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Illinois			U.S.A.						Montgomery County,				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			NIH Clinical Center, Bethesda, MD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Bethesda									Clerk			Stockbrokerage	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS	
Maryland			Baltimore			Towson						8213 Pleasant Plain Rd. 21204	
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			LAST	
Verne			M.			Ray, Jr.			Dolores			Faxel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
No			214-54-2327			Mr. Richard Wolfe, Husband (same as above)							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY/CARDIAC ARREST													
1940 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC ADRENAL CARCINOMA													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any (c) DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PULMONARY METASTASES													
20a. DATE OF OPERATION			20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY?			20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY	STATE
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from July 3, 1980, to August 6, 1980, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on August 6, 1980, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) did XXXXXX the body after death.													
22b. SIGNATURE <i>Richard A. Knaeck</i>			22c. DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22d. DATE SIGNED 8-7-80				
22e. ADDRESS National Institutes of Health Clinical Center, Bethesda, MD 20205													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-11-1980			23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph's Church			23d. LOCATION CITY OR TOWN Cem. Emmitsburg			COUNTY	STATE Maryland
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc., Towson, Maryland			ADDRESS 1050 York Road			25a. DATE REC'D. BY REGISTRAR AUG 11 1980			25b. REGISTRAR'S SIGNATURE <i>John J. Kelly</i>				

68-82 X 2000
GM A post Ward
2000 A Ward

D. Rogers

TO HOSPITAL OR ATTENDING PHYSICIAN: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

24 hours after death, 24 hours after birth, 4 months after death

D. Perry released to sign per

D. Perry

relinquished by the hospital or attending physician.

3702

BP

DHMH-16 25M
(VRA 15, 4) 1/791. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH80 21356
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST <u>XIXXXXXXXX</u>	MIDDLE <u>XXXXX</u>	LAST <u>X</u>	2a. DATE OF DEATH MONTH Dec.	MONTH 12	DAY Aug 12	YEAR 1980	2b. HOUR 4:36pm				
3. SEX Female			4. RACE White	5. DATE OF BIRTH MONTH Dec.			DAY 22	YEAR 1896	6. AGE (IN YEARS LAST BIRTHDAY) 83 yrs	IF UNDER 1 YEAR MONTHS YRS	IF UNDER 24 HRS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Virginia</u>			7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Montgomery County</u>					
10. CITY OR TOWN OF DEATH <u>Silver Spring</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Holy Cross Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Housewife</u>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE <u>Maryland</u>			13b. COUNTY <u>Montgomery</u>			13c. CITY OR TOWN <u>Wheaton</u>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS <u>2607 Finley Street, Wheaton</u>		
14. FATHER'S NAME FIRST <u>HENRY</u>			MIDDLE <u></u>	LAST <u>IVEY</u>	15. MOTHER'S MAIDEN NAME FIRST <u>MINNIE</u>			MIDDLE <u>MAE</u>	LAST <u>KEYES</u>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			16b. SOCIAL SECURITY NO. <u>577-22-5805</u>			17. INFORMANT ADDRESS <u>1602 FLORA LANE, SILVER SPRING, MD.</u>								
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4140</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			DUE TO OR AS A CONSEQUENCE OF (b) <u>Coronary artery disease</u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>								
			DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic heart disease</u>			5 years								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION			19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
		22a. I certify that (1) this hospital attended the deceased from <u>1970</u> 19 to <u>8-12-80</u> 19, that (1) we last saw the deceased alive on <u>8-12-80</u> 19, and that in (my) <u>our</u> opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.												
		22b. SIGNATURE <u>Morris Perry</u>			22c. DEGREE <u>M.D.</u>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <u>8-12-80</u>			
		22e. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MORRIS PERRY</u>			22f. ADDRESS <u>11602 GEORGIA AVENUE, SILVER SPRING, MD.</u>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>8/15/80</u>		23c. NAME OF CEMETERY OR CREMATORIAL <u>NATIONAL MEMORIAL PARK</u>			23d. LOCATION CITY OR TOWN <u>FALLS CHURCH</u>		23e. STATE <u>VIRGINIA</u>					
24. FUNERAL DIRECTOR NAME <u>FRANCIS J. COLLINS</u>		ADDRESS <u>500 UNIV. BLVD., W., SILVER SPRING, MD. 20901</u>		25e. DATE REC'D. BY REGISTRAR <u>AUG 14 1980</u>			25f. REGISTRAR'S SIGNATURE <u>Francis J. Collins</u>							

~~SECRET~~
Over A DUA

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						8021357		
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH	MONTH	DAY		
FIRST		MIDDLE	LAST	1980		1980		
BERNARD			WOOL	AUGUST 19,		1980		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR		
MALE	WHITE	MONTH	DAY	YEAR	71	9:49P M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY		
10. CITY OR TOWN OF DEATH SILVER SPRING		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) HOLY CROSS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTING SPEC.		
13a. STATE MARYLAND		13b. COUNTY MONTGOMERY		13c. CITY OR TOWN SILVER SPRING		13d. STREET ADDRESS 1702 BELVEDERE BOULEVARD		
14. FATHER'S NAME FIRST MORRIS		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST GERTRUDE		MIDDLE	LAST FELDMAN	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 578-38-5254A		17. INFORMANT BESSIE WOOL, same as #13		ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR Accident</u>								
436- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								
DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Diabetes mellitus, Arteriosclerotic heart disease</u>								
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE
22a. I certify that (1) this hospital attended the deceased from <u>Aug 19</u> 1980 to <u>Aug 19</u> 1980, that (1) (we) lost saw the deceased alive on or above, (1) (we) (did) (did not) view the body after death.								
23a. SIGNATURE <u>Jerome J. Schnapp, M.D.</u>								DEGREE
23b. PHYSICIAN'S NAME (TYPE OR PRINT) JEROME J. SCHNAPP, M.D.								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>
22b. ADDRESS 11161 NEW HAMPSHIRE AVENUE, SILVER SPRING, MD.								22c. DATE SIGNED Aug 20, 1980
23c. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23d. DATE 8/21/1980	23e. NAME OF CEMETERY OR CREMATORIAL JUDEAN MEMORIAL GARDENS		23d. LOCATION CITY OR TOWN OLNEY, MONTGOMERY, MARYLAND			
24. FUNERAL DIRECTOR DAVID M. STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.		25a. DATE REC'D. BY REGISTRAR AUG 25 1980		25b. REGISTRAR'S SIGNATURE <u>Jerome J. Schnapp, M.D.</u>				
ADDRESS								

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be forwarded for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												80 21358
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			REG. NO.
CATHARINE I			WORK			8/30/80			8/30/80			1000
3. SEX Female			4. RACE Caucasian			5. DATE OF BIRTH MONTH October 19 1925			6. AGE (IN YEARS LAST BIRTHDAY) 54 yrs.			1000
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Penn.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			7c. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery County, MD.			1000
10. CITY OR TOWN OF DEATH Bethesda			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Suburban Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher			12b. KIND OF BUSINESS OR INDUSTRY Education			1000
13a. STATE Md.			13b. COUNTY Montgomery			13c. CITY OR TOWN Gaithersburg			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			1000
14. FATHER'S NAME FIRST Sidney MIDDLE Charles LAST Work			15. MOTHER'S MAIDEN NAME Tessie			16. ADDRESS 717 Tiffany Drive			16. ADDRESS 717 Tiffany Dr., Gaithersburg, Md.			1000
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 205-16-3260			17. INFORMANT Helen Hensberger			18. APPROXIMATE INTERVAL BETWEEN DEATH AND DEATH 1 year			1000
18. CAUSE OF DEATH: (Enter only one cause per line for 1a, 1b, and 1c) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 5119			DUE TO, OR AS A CONSEQUENCE OF 1b) Bopoxin			18. CAUSE OF DEATH: (Enter only one cause per line for 1a, 1b, and 1c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION LISTED IN PART 1 1c) Plac Egan + Anemia			18. CAUSE OF DEATH: (Enter only one cause per line for 1a, 1b, and 1c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION LISTED IN PART 1 Carcinoma + breast + metastases in plac Egan			1000
19. DATE OF OPERATION			20. CONDITION FOR WHICH OPERATION WAS PERFORMED			21a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			1000
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			21d. LOCATION STREET CITY OR TOWN COUNTY STATE			1000
21e. INJURY OCCURRED WHITE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21f. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21g. LOCATION STREET CITY OR TOWN COUNTY STATE			21h. LOCATION STREET CITY OR TOWN COUNTY STATE			1000
22a. I certify that (I) (this hospital) attended the deceased from 19 77 to Aug 1980, that (we) lost saw the deceased alive on Aug 28 1980, and that in (my) our opinion death occurred on the date and hour and from the causes stated above, (we) (did) (did not) view the body after death.												22c. DATE SIGNED 8-30-80
22b. SIGNATURE W.H. Killay for J.W. Egan			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. ADDRESS 8218 Wisconsin Ave Bethesda			
22e. PHYSICIAN'S NAME (TYPE OR PRINT) W.H. Killay for J.W. Egan			22f. ADDRESS 8218 Wisconsin Ave Bethesda			22g. ADDRESS 8218 Wisconsin Ave Bethesda			22h. ADDRESS 8218 Wisconsin Ave Bethesda			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/2/80			23c. NAME OF CEMETERY OR CREMATORIAL Mt. Rose Cemetery			23d. LOCATION CITY OR TOWN York			1000
24. FUNERAL DIRECTOR Isabell Sandison 316 E. Diamond Ave., Gartner Sandison F. H. Gaithersburg, Md.			25a. DATE REC'D. BY REGISTRAR SEP 4 1980			25b. REGISTRAR'S SIGNATURE Isabell Sandison			25c. COUNTY York			1000

know I wanted

INTERSTATE NUMBER

the 1936

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TCI FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be retained for use in the burial, transit, or removal. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or if item 18 shows any injury, or certain traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 80 21359				
1 - FOR STATE REGISTRAR			2a. DATE OF DEATH MONTH DAY YEAR 8- 11-80							7b. HOUR 11:20 AM				
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST Joseph A. Workman			2b. DATE OF DEATH MONTH DAY YEAR 8- 11-80			7b. HOUR 11:20 AM					
3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 10- 3- 31			6. AGE (IN YEARS LAST BIRTHDAY) 74					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASHINGTON, D.C.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			7c. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			7d. BALTIMORE CITY OR COUNTY OF DEATH MONTGOMERY					
10. CITY OR TOWN OF DEATH Silver Spring			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Holy Cross Hospital			12a. USUAL OCCUPATION COMPUTER SYSTEMS MGR. DEPT OF ARM			12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MARYLAND			13b. COUNTY MONTGOMERY			13c. CITY OR TOWN SILVER SPRING			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 912 ANNMORE DRIVE		
14. FATHER'S NAME JOSEPH L. WORKMAN			15. MOTHER'S MAIDEN NAME MARGUERITE									LAST ARNOLD		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 1952-1960			17. INFORMANT MARY M. WORKMAN			18. ADDRESS SAME AS 13			WIFE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Bundu genic CA with</i> (c) <i>Metastasis</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 10</u> , 1980, to <u>Aug 12</u> , 1980, that (I) (we) last saw the deceased alive on <u>Aug 10</u> , 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <i>Merle L. Endino</i>			22c. DEGREE			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED					
23a. PHYSICIAN'S NAME (TYPE OR PRINT) MERLE L. ENDINO MD			23b. ADDRESS 11620 KEMP MILL ROAD, SILVER SPRING, MD.											
23a. BURIAL, CREMATION, REMOVAL BURIAL			23b. DATE 8/14/80			23c. NAME OF CEMETERY OR CREMATORIAL CHLTENHAM VETERANS			23d. LOCATION CITY OR TOWN CHLTENHAM			COUNTY MARYLAND STATE		
24. FUNERAL DIRECTOR FRANCIS J. COLLINS NAME <i>Francis J. Collins</i> ADDRESS 500 UNIV. BLVD., W., SILVER SPRING, MD. 20901			25a. DATE REC'D. BY REGISTRAR AUG 14 1980			25b. REGISTRAR'S SIGNATURE <i>P. Kelly</i>								

Photograph

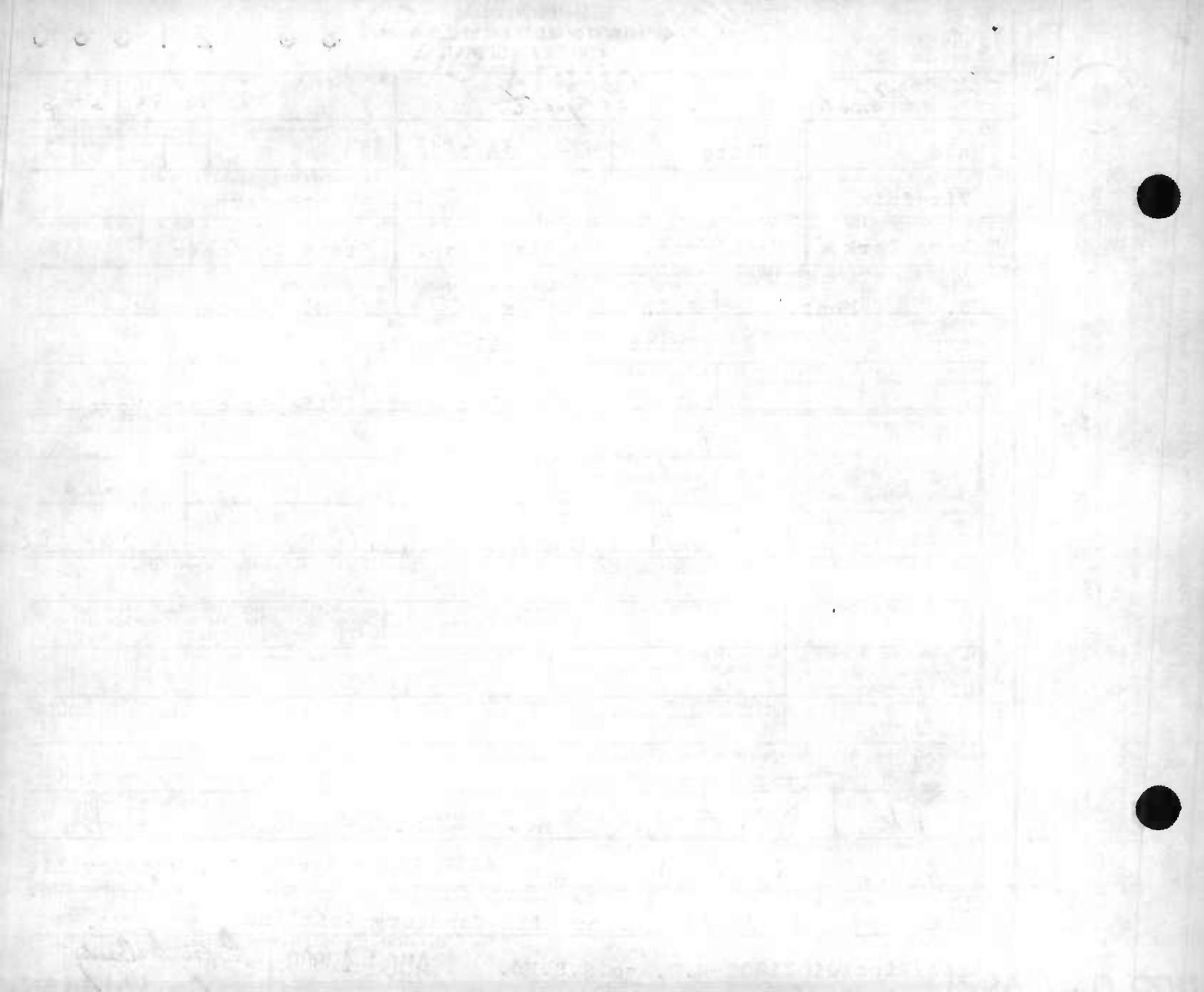
0821 * 100A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8021360	
1. DECEASED NAME (TYPE OR PRINT)			FIRST Charles	MIDDLE H.	LAST Wyatt	2a. DATE OF DEATH MONTH May			DAY 16	YEAR 1900	2b. HOUR 640 PM
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH May			6. AGE (IN YEARS LAST BIRTHDAY) 80			# UNDER 1 YEAR MONTHS YRS.	
7a. BIRTHPLACE COUNTRY Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Montgomery			# UNDER 24 HRS HOURS MIN	
10. CITY OR TOWN OF DEATH Takoma Park		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Washington Adventist Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Steam Engineer			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Md.		13b. COUNTY Mont.		13c. CITY OR TOWN S.S.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 864 N. Hampton Drive	
14. FATHER'S NAME FIRST Henry		MIDDLE Wyatt		15. MOTHER'S MAIDEN NAME FIRST Sally Reiley						MIDDLE LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO (IF YES, GIVE WAR OR OATES) No		16c. INFORMANT 247 01 9656			17. ADDRESS Thelma Wyatt (Wife) Same as above			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5:40 pm 8/10/80	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Respiratory arrest</u> 1629 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost										DUE TO, OR AS A CONSEQUENCE OF (b) <u>Aspiration pneumonia - bony spine</u> 0/10/80 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Methotrexate bronchitis Ca</u> 2/80 - D	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Mark D Andrews</u>			DEGREE MD			22c. DATE SIGNED 8/11/80					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark D Andrews MD			22e. ADDRESS 4140 Sandy Spring Rd. Burtonsville Md.								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/13/80		23c. NAME OF CEMETERY OR CEMETORY Cedar Hill Cemetery Suitland			23d. LOCATION CITY OR TOWN Suitland		COUNTY PG		STATE Md.
24. FUNERAL DIRECTOR NAME Hines/Rinaldi			ADDRESS 11800 N.H.Ave.S.S.Md.			25e. DATE REC'D. BY REGISTRAR AUG 14 1980			25b. REGISTRAR'S SIGNATURE Hilary McReady		



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

80 21361
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR
EMMA			LOU	YOUNG		8	15	1980	23 15	
3. SEX	4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR	
Female	CAUC.	8 24 1896	83 yrs.			8 15 1980 23 15			M	
7a. BIRTHPLACE 1 STATE OR FOREIGN COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Washington, D.C.		U.S.A.				MONTGOMERY			MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BETHESDA		SUBURBAN				Homemaker			Home	
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
MD	MONTGOMERY	BETHESDA	4858 BATTERY LANE							
14. FATHER'S NAME FIRST		MIDDLE	15. MOTHER'S MAIDEN NAME FIRST		16. ADDRESS					
Robert		Shelton	Barbara		9215 Topeka St. Bethesda, Maryland			Bonhoff		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		George W. Young Jr.				
No		593-03-1724D		ADDRESS					20034	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) PNEUMONIA 888- Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last.										5 DAYS
DUE TO, OR AS A CONSEQUENCE OF (b) FRACTURED WRIST DUE TO, OR AS A CONSEQUENCE OF										10 DAYS
(c) CEREBRO VASCULAR ARTERIOSCLEROSIS										10-5 YRS
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).										
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION CAST 8/7/80		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED? COLLES FRACTURE R+ WRIST		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 7 P.M. 86 19 80		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) FELL AT Home						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION STREET 4858 BATTERY LANE BETHESDA		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion								
ACTUAL SIGNATURE		TITLE (SPECIFY) Francis C. Mayle, M.D. D.Y.T. MEDICAL EXAMINER								
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 8200 Wisconsin Ave. BETHESDA MD 20014								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug 19, 1980		23c. NAME OF CEMETERY OR CREMATORIAL Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN SUITLAND		COUNTY MARYLAND		
24. FUNERAL DIRECTOR Robert A. Pumphrey		ADDRESS Funeral Homes, P.A. Bethesda, Maryland		25a. DATE REC'D. BY REGISTRAR AUG 18 1980		25b. DATE REC'D. BY REGISTRAR Fifty-Second				
DHMH-17 (VR A15 ME (5)) 15M 7/77										

08961304

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please leave carbon papers. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8021362		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			20. DATE OF DEATH MONTH DAY YEAR			21. HOUR			
GERTRUDE M. ZMOLA						Aug 21, 1980			5457A M			
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		
Female		White		Dec. 15, 1919			60 YRS.			MONTHS DAYS HOURS MIN		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Indiana		U.S.A.					Montgomery					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Chevy Chase		Beth. Ret. & Nursing Ctr.					Home Economist			Self Employed		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE Md		13b. COUNTY Montgomery		13c. CITY OR TOWN Bethesda			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 5409 Newington Rd.		
14. FATHER'S NAME FIRST August		MIDDLE		15. MOTHER'S MAIDEN NAME FIRST Rosa			MIDDLE			LAST Stockinger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b. SOCIAL SECURITY NO. 044-36-3407		17. INFORMANT Paul C Zmola, Husband. Same as item 13.			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>JACOB-Creutzfeldts Disease</u>												
0461 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) None												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN				
22a. I certify that <input checked="" type="checkbox"/> (I) (we) attended the deceased from 9-21-78 19 to 8-21-80 19, that <input checked="" type="checkbox"/> (I) (we) last saw the deceased alive on 8-15-80 19, and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I) (we) did <input type="checkbox"/> did not <input type="checkbox"/> view the body after death.												
22b. SIGNATURE <u>Frank C. Blackburn</u>		22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED Aug 21, 1980				
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Frank C. Blackburn, M.D.		22f. ADDRESS 5401 Western Ave. N.W. Wash., D.C.										
23a. BURIAL, CREMATION, REMOVAL (SPEC #) Burial		23b. DATE 8/26/1980		23c. NAME OF CEMETERY OR CREMATORIAL St. Joseph Cemetery			23d. LOCATION CITY OR TOWN Mishawaka			STATE COUNTY Indiana		
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. 5130 Wisc. Ave. N.W. Wash., D.C.		ADDRESS C.			25a. DATE REC'D. BY REGISTRAR AUG 6 1980			25b. REGISTRAR'S SIGNATURE <u>John J. Murphy</u>				

YOUNG'S

REF ID: A2.300

卷之三

before the claim is made.

• 85 • *THE JOURNAL OF CLIMATE* • 15

not in. 80

about synonymy

59

卷之二

surface

155

• इनका एक बहुमत यह है कि वो विद्युत विद्युत का विद्युत है।